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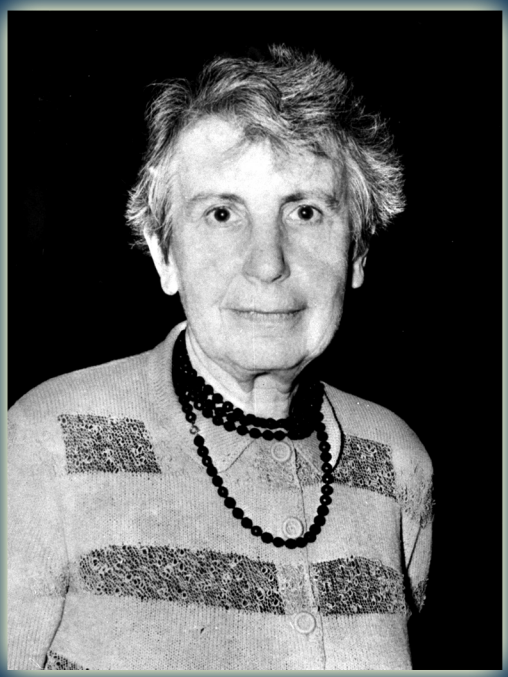

Anna Freud (1895-1982)

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Message from Editors

We have obtained good achievement with you in 2015, for which we are thankful to you, spotlight of which is as under: 24+ Regular Issues, 16+ Special Issues, Member of 10+ World Libraries, 4000+ Authors, Have 50+ Indexing and Abstracting Partners, We Indexing with 26+ Universities, 760857+ Site Visitors, 6.39 Impact Factor (2015), 3000+ Register Site Users, Connected with 10+ Organizations, Connected with 7+ Smarts Publishers, 400+ Cited Titles, 8 Different Licenses, Global Rank ^9.179.008, and really, this is not possible without your warm support and love.

We are giving farewell to you 2015 with this issue. This is time to forget our mistakes, digest our achievements and to go forward towards future.

We commit you to give much more services in 2016. Thanks again for joining us and we hope, your publishing experience with us will be happier.

Wish you a merry Christmas…

Dr. Suresh Makvana[1]
(Editor in Chief)
Mr. Ankit Patel[2]
(Editor)

[1] ksmnortol@gmail.com
[2] info.ankitpatel@asia.com

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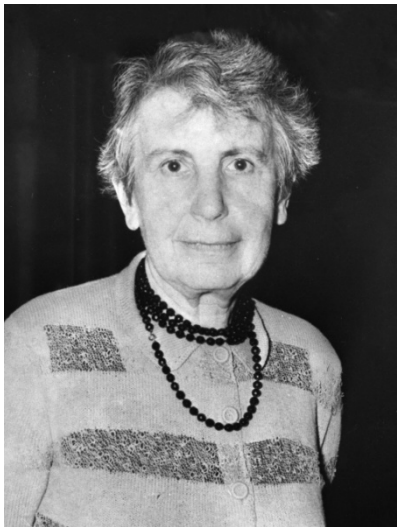
Person of the Issue: Anna Freud (1895-1982)

Ankit Patel[1]



Born	December 3, 1895, Vienna, Austria
Died	October 9, 1982, London, United Kingdom
Citizenship	Austrian
Known for	Work on the nature of ego Founder of child psychoanalysis Defense mechanisms
Training Location(s)	Doctor of Medicine (honorary), University of Vienna, (1975) Doctorate of Science (honorary), Jefferson Medical College, (1964) Doctor of Law (honorary), Clark University, (1950)
Primary Affiliation(s):	International Psychoanalytical Association, (1927-1934) Vienna Psychoanalytical Training Institute, (1935-1938) The Hampstead War Nursery, (1941-1945) The Hampstead Child Therapy Clinic, (1952-1982)

The name Freud is most often associated with Sigmund, the Austrian doctor who founded the school of thought known as psychoanalysis. But his youngest daughter, Anna, was also an influential psychologist who had a major impact on psychoanalysis, psychotherapy, and child psychology. Anna Freud did more than live in her father's rather long shadow. Instead, she becomes one of the world's foremost psychoanalysts. She is recognized as the founder of child psychoanalysis, despite the fact that her father often suggested that children could not be psychoanalyzed.

Anna Freud was born December 3, 1895 in Vienna, Austria. As the daughter of Sigmund Freud, she was inescapably steeped in the psychoanalytic theories of her famous father; however, she did more than simply live in his shadow, pioneering the field of child psychoanalysis and extending the concept of defense mechanisms to develop ego psychology. After finishing her secondary education in 1912 at Cottage Lyceum in Vienna, she completed teachers' training and worked at her alma mater as a classroom teacher for five years. Of her school years she declared that she learned far more at home from her father and his guests. Indeed, she acquired knowledge of psychoanalysis from this group to which few others had access, and this grounded her life-long contributions to the field.

[1] Clinical Psychology, Dept. of Psychology, Sardar Patel University, Vallabh Vidyanagar, Gujarat

The details of Anna Freud's personal life are consistently cryptic, but that her father was the only man in her life long-term is certain. Letters between her and Eva Rosenfeld during the Vienna years are a rare opportunity to catch a glimpse of the very private Anna. According to contributor Gunter Bittner, the letters *"convey the picture of an affectionate, intensely human Anna Freud without a trace of rigidity or psychoanalytic orthodoxy. Here...is a shy young woman of deep feeling. " Indeed she said of herself, "I was always looking outside myself for strength and confidence but it comes from within. It is there all the time."*

Anna Freud died on October 9, 1982 at the age of 86 at her London home. A tribute published in the *New York Times* following her death, noted that *"Freud virtually invented the systematic study of the emotional and mental life of the child and elaborated on it in 50 years of observation, discussion and writing."* She stepped out from beneath her father's very long shadow to make her own very substantial mark upon the field of psychoanalysis, but always remained loyal to his memory and determined to secure his legacy. Upon her death, the Freud family home became a museum dedicated to him.

TIME LINE

1895- Born December 3 in Vienna, the sixth and youngest child of Sigmund and Martha Freud is born. They name her Anna.

1905- Anna starts school at Salka Goldman Cottage Lyceum - she will later return here as a teacher.

1909- From the age of 14 Anna Freud's interest in psychoanalysis was clear. This paved the way for the rest of career.

1912- Finished schooling at Cottage Lyceum, Vienna

1914- During a holiday to England, WW1 breaks out, meaning Anna must flee back to Vienna as an enemy alien.

1914 Sept.- Returning to her old school, Salka Goldman Cottage Lyceum, she begins her teacher qualification.

1918- Although parent/child psychoanalysis is deemed controversial, this series of psychoanalysis was, in the end, concluded as successful.

1920- After 6 years at her old school she finally qualifies as a teacher. This experience becomes invaluable in her child psychoanalysis research.

1920- Attended the International Psychoanalytic Congress at The Hague

1922- Anna reads a formal paper to the Viennese Psycholanalytic Society in order to become an accredited member.

1922 Oct.- Anna attends the International Psychoanalytic Congress of Psychoanalysis in Berlin, founded by her father.

1922- Presented paper Beating Fantasies and Daydreams to Vienna Psychoanalytic Society and became a member

1922-1935 Introduction to Psychoanalysis

1925- Taught seminar at Vienna Psychoanalytic Institute on technique of Child Analysis

1927- Introduction to the Technique of Child Analysis

1927-1934- General secretary of the International Psychoanalytic Association

1935- Director of Vienna Psychoanalytic Training Institute

1936- The Ego and the Mechanisms of Defense

1937- 'The Ego and the Mechanisms of Defence', the first of Anna's books, is published in English. To this day it remains a very important work.

1938- As the Nazis enter Vienna, the Jewish Freud family leave Austria and flee to England.

1939- Anna's father Sigmund Freud dies from jaw cancer less than a year after their move to England.

1939- With the outbreak of World War Two Anna sets up residential war nurseries in Hampstead for homeless children of war.

1939-1945-Infants without Families

1941-1945- Harsh divisions between Anna and her colleague Melanie Klein, documented in a series of Controversial Discussions, end when the British Psycho-Analytic Society split into three training divisions, however the Society remained whole

1945-1956- Indications for Child Analysis and other papers

1947- Establishment of Hampstead Child Therapy Courses and children's clinic

1950- Honorary doctorate from Clark University

1950 to death- traveled back and forth to US to give lectures

1951- Anna's mother, Martha Freud, dies.

1956-1965 Research at the Hampstead Child Therapy Clinic

1965- Anna's seventh title is published, one of her most important books which continues to make contributions in the fields of education and paediatrics.

1965- Normality and Pathology in Childhood

1967- Problems of Psychoanalytic Training, Diagnosis and the Technique of Therapy

1967- Received C.B.E. from Queen Elizabeth II

1968- Publication of collected works

1970- Psychoanalytic Theory of Normal Development

1972- Received honorary medical doctorate from Vienna University

1973- Received honorary president of International Psychoanalytic Association

1975- Anna receives her MD from the University of Vienna.

1981- Anna is awarded with a PhD from Goethe Institute in Frankfurt.

1982- Died October 9th

1983- Hampstead Clinic becomes Anna Freud Center as tribute to her memory

1986- Home of 40 years changed into the Freud Museum

AWARDS & ACHIEVEMENTS

- In 1965, she received the Dolly Madison Award.
- In 1967, she was named a Commander of the British Empire by Queen Elizabeth II.
- In 1975, she was awarded an MD degree from the University of Vienna. The same year, she also received the Grand Decoration of Honor in Gold.

MAJOR WORKS

- She created the field of child psychoanalysis and her work contributed greatly to the understanding of child psychology. She noted that children's symptoms differed from those of adults and were often related to developmental stages.
- One of her most significant published works is 'The Ego and the Mechanisms of Defense' in which she outlined and expanded upon her father's theory of psychological defense mechanisms.

QUOTES

"Creative minds have always been known to survive any kind of bad training."

"I was always looking outside myself for strength and confidence but it comes from within. It is there all the time."

"Create around one at least a small circle where matters are arranged as one wants them to be."

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Effect of Yogic Exercise on Emotional Maturity of B.Ed. Students

Dr. Mahesh Kumar Muchhal[1]*, Arun Kumar[2]

ABSTRACT

The sample of the present study comprised 100 Students of B.Ed class from colleges of Ambala district. The post test experimental and control group design was followed. There were two groups (control group and experimental group) 50 students were assigned in each group. The experiment was conducted for 30 days with yoga exercise Shatkriyas (Kapalbhati and Trataka), Pranayamas (Anulom-Vilom, Shitali, Shitkari and Bhramari) and Meditation regularly in the morning. Emotional Maturity Scale by Yashvir Singh & Dr. Mahesh Bhargava (1990) was used.

Keywords: *Yoga exercise and Emotional Maturity.*

The wealth of India, Yoga is one of the greatest gifts of India to the world. Part of daily routine for the Indians of yore, today yoga has become one of the most popular systems of health and healing, all over the world. It is also a spiritual pursuit for many seekers of truth. In the modern world, western countries like America use yoga as a tool for mental, physical and spiritual upliftment .Life is full of stress as a result of existence in the fast, mechanized and competitive way of life. Moreover modernization, urbanization, materialism, competition and ever changing trends of society tend to put stress on individuals of all age groups.

In the present circumstances, youth as well as children are facing difficulties in life. These difficulties are giving rise to many psychosomatic problems such as anxiety, tension, frustration and emotional upsets in day to day life. So the study of emotional life is now emerging as a descriptive science, comparable with anatomy it deals with an inter play of forces with intensities and quantities. Available tests are crude and measure chiefly the degree of dependence. But the test measures the difficult aspects of emotional maturity. As self-acceptance is an important aspect of maturity ways **Wenkart,** it must be preceded by acceptance from others. Emotional maturity is concerned primarily with self-control and expression. The teacher develops through a variety of experiences. For instance, the school can help the adolescents to arrange situations that will enable them to judge and evaluate their own behaviour. The school can provide a variety of supervised playground activities that permit children to free rather than rigidly prescribe art expression and help children take part in discussions in the classroom or in private conference.

[1] Associate Professor, Digamber Jain (PG) College Baraut, Baghpat (U.P)
[2] Assistant Teacher, P.S Belda Bujurg, Deoband Saharnapur.
*Responding Author

Emotional maturity has not only a negative aspect but also positive one and emotional upsets in day-to-day life.

Actually, emotional maturity is not the only effective determinant of personality pattern but it also helps to control the growth of adolescent's development. The concept of mature emotional behaviour at any level is that which reflects the fruits of normal emotional development. A person who is able to keep his emotions under control, who is able to break delay and to suffer without self-pity might still be emotionally stunted and childish.

REVIEW OF LITERATURE

Emotional maturity is related to environmental factors **(Kaur, 2000).** Emotional maturity and intelligence are related **(Kaur, 2001).** Slum and urban areas children's have different emotional maturity **(Muley, Patnam and Vasekar, 2003).** Emotional expression skills of adolescents should be channelized for their effective mental health and personality development. Also post-adolescent boys have higher emotional maturity than females **(Chouhan and Bhatnagar, 2003).** There exists a positive relationship between emotional maturity and self-concept of secondary level students **(Gakhar, 2003).** There exists some relationship between emotional intelligence and trait anxiety in adolescents **(Markham, 2004).** Emotional intelligence is related to ethical decision making **(Scott, 2004).**

OBJECTIVES

1 To study the emotional maturity of yoga students and Non-yoga students of B.Ed.

2 To compare the emotional maturity of yoga students and Non-yoga students of B.Ed.

Hypotheses

H1 There is no significant difference in Emotional maturity of B.Ed students of experimental and control groups at pre-test.

H2 There is no significant difference in Emotional maturity of B.Ed students of experimental and control groups at post-test.

H3 There is no significant difference in the mean reduced scores of Emotional maturity between B.Ed students of experimental and control groups.

Design of the Study

It was an experimental study based on randomized matching A pre-test, post-test, control group design with one experimental group was employed to conduct the present experimental study. Treatment was the independent variable and dependent variable is academic stress. Training in Yoga exercise Shatkriyas (Kapalbhati and Trataka), Pranayamas (Anulom-Vilom, Shitali, Shitkari and Bhramari) and Meditation was given to the experimental group for 30 days one hour in morning regularly.

Sample

Sample of 100 B.Ed from colleges of Ambala Districts were taken in the present study. This was further categorized in to control group (50) and experimental group (50). We used randomize method to select the B. Ed students for data.

Tools Used

1. Emotional Maturity Scale by Yashvir Singh & Dr. Mahesh Bhargava (1990)
2. Shatkriyas (Kapalbhati and Trataka)
3. Pranayamas (Anulom-Vilom, Shitali, Shitkari and Bhramari) & Meditation

RESULTS

Table 1, Means, S.D.'s and t-ratios for pre-test and post-test scores on Emotional Maturity of the Experimental and Control Groups.

Groups	Pre-Test			Post-Test		
	Mean	S.D	't' Value	Mean	S.D	't' Value
Yoga Students	92	23.78	0.196 (NS)	81.03	17.54	2.146*
Non-Yoga Students	91.07	23.45		89.85	23.179	

*** Significant at 0.05 level,** N.S. – Not Significant

Table 2, Means, S.D's and t-ratios of total Mean reduced scores of Experimental and Control Groups on Emotional Maturity.

Component	Groups	N	Mean	SD	't' Value
Emotional Maturity(Total)	Yoga Students	50	10.97	7.081	9.648**
	Non-Yoga Students	50	1.22	0.958	

**Significant at 0.01 level

DISCUSSION

Entries made in **Table 1** Hypothesis H1 "There is no significant difference in Emotional maturity of B.Ed students of experimental and control groups at pre-test" was accepted. Hypothesis H2 "There is no significant difference in Emotional maturity of B.Ed students of experimental and control groups at post-test" was rejected in favour of the finding that yogic practices helped in improving of Emotional Maturity.

Entries made in **Table 2** t-ratio for the mean reduced scores between the experimental and control groups on Emotional maturity was found to be significant at 0.01 level of confidence (t=9.648). Thus, H3 was rejected as the experimental group students who were exposed to yogic practices exhibited improvement Emotional maturity as compared to their counterparts of the control group.

CONCLUSION

On the behalf of above discussion we can say that yoga effects emotional maturity of the B.Ed students. We can emotionally stable through yoga practices can yoga effects our nervous system and glandular system which makes our emotionally mature. So yoga helps to improve emotional maturity.

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Work Stress and Organisational Citizenship Behaviours (OCBs) in Call Centers Employees

Sunita[1], Urvashi Singh[2], Shalini Singh[3]*, Rajnee Sharma[3]

ABSTRACT

The present study was conducted to examine the relationship between organisational stress and organisational citizenship behaviours (OCBs) in employees of call centers. The study also further explored as how stress at work set-up has negative impact on OCBs. A sample of 250 employees working in call centre of Gurgaon belonging to an age group of 25-30 years were selected on availability basis. All were working married couples living in nuclear families. Job stress survey (Spielberger & Vagg, 1999) and Organisational Citizenship Behaviour (Bateman & Organ, 1983) were administered. Data was analysed by using simple correlation and multiple regression. Results showed the negative relationship between organisational stress and OCBs. Results of regression analysis also exhibited the negative impact of stress on OCBs. The implications for the employees are discussed.

Keywords: *Organisational stress, Organisational Citizenship Behaviours.*

Human beings have many biological, social and psychological needs. When these needs are not satisfied they experience stress. Stress is a word derived from the latin word 'stringer' means to draw tight. Stress is a consequence of or a general response to all action or situation that places special physical or psychological demands, or both on a person. *Stress involves an interaction of the person and the environment. The physical or psychological demands from the environment that cause stress are called stressors.* Medical researcher Hans Selye (1956) first used the word 'stress' to describe the body's biological response mechanisms. He defined stress 'as any external events or internal drive which threatens to upset the organismic equilibrium. However, the body has only a limited capacity to respond to stressors. The workplace makes a variety of demands on people and too much stress over too long a period of time, exhausts their ability to cope with those stressors. Selye has described three stages that an individual encounters in stressful situation, i.e., Alarm reaction, Resistance and Exhaustion.

Stress may be acute or chronic in nature (Akinboye and Adeymo, 2002). It occurs in different forms, i.e., may be psychological, emotional, social or occupational. Job related stress

[1] Asstt. Professor of Psychology, Govt. College, Dujana
[2] Asstt. Professor of Psychology, Draunacharya College, Gurgaon
[3] Deptt. of Psychology, M.D. University, Rohtak
*Responding Author

experienced by workers at work is called job stress. There are number of factors, i.e., poor working conditions, excessive work load, shift work, long hours of work, role ambiguity, role conflict, shifting hours, role conflict, poor relations with boss, colleagues or subordinates, risk and danger in work set up etc. that lead to stress.

Health and Safety Executive (2004) defines job stress in terms of adverse reactions of people to excessive pressures or other types of demand placed on them. Studies have shown that workers suffering from stress exhibit decreased productivity, absenteeism, have a higher accident rate, low morale, more interpersonal conflict with supervisors and colleagues (Cranwell & Abbey, 2005; Health and Safety Executive, 2004). Some jobs are highly demanding and stressful by virtue of their demands. Long working hours, night shifts, high work targets, lots of identity are some of the major demanding features of operators working in the call centre industry. Such strenuous and stressful job profile has its linkage with Organisational Citizenship Behaviours (OCBs) as the work stress causes negative effect on performance and OCB's (Bragger, Sreduichi, Indovicro and Rosner, 2005).

Organisational citizenship behaviour is the technical psychological term that can be simply defined as the compilation of individual behaviours in a group setting. It was first defined by organ in 1988 as an individual behaviour which is not rewarded by a formal reward system… but that when combined with the same behaviour in a group results in effectiveness. It deals with five common types of behaviours when grouped together results into effectiveness in the group. It encompasses altruism (desire to help or otherwise assist another individual, while not expecting a reward in compensation for that assistance), courtesy (a behaviour which is polite and considerate towards other people), sportsmanship (exhibiting no negative behaviour when something does not go as planned or when something is being perceived as annoying, difficult or frustrating), conscientiousness (behaviour that suggests a reasonable level of self control and discipline which extends beyond the minimum requirements expected in that situation) and civic virtue (behaviour which exhibits how well a person represents an organization with which they are associated and how well social support system is there in colleagues). As OCB is a construct comprising of various dimensions and in current scenario where maximum of people are working in private world. There is a great job stress and how these two variables correlate and have cause and effect relationship is a matter of investigation. Taking this perspective in mind, the present study focuses on following objectives:-

OBJECTIVES

- To study the relationship between work stress and organisational citizenship behaviours in employees of call centres.
- To study the role of work stress on the organisational citizenship behaviours of call centre employees.

METHOD

Sample

The sample for this investigation was obtained from the population of all the operators of call centre organisations located in Gurgaon as this considered a major hub of the call centre industry. The total sample of 250 call centre employees whose major task was to receive and answer the international calls of their customers. These employees were working under 24×7 conditions with different shifts. All belonged to an age group of 24-30 years, married and atleast Graduates. Their minimum work experience was 4-5 years and it was in corporate sector only.

Measures

(I) ***Job Stress Survey (Speilberger & Vagg, 1999)*** : It assesses the perceived severity and frequency of occurrence of 30 stressful work related events encountered by employees in wide variety of occupations. It consists of 3 subscales, job stress index, job stress severity and job stress frequency. Job stress index scale provides an estimate of the overall level of occupational stress. The higher the score, the more is the work stress.

(II) ***Organisational Citizenship Behaviours (OCB)***: The measure of organisational citizenship behaviour was assesses by revised questionnaire of original work of Boxeman & Organ (1983), Morman and Blakely (1995) and Chattopadhyay (1999). Earlier scale had 11 reliable factors and 48 items. Further it was adopted and revalidated by Jain in 2003. The earlier questionnaire dealt with 5 factors, i.e., civic virtue, conscientiousness, altruism, courtesy and sportsmanship. But the revised questionnaire deals with Emotional support (ES), Concern for Organisational Resources (COR), Conservation of Time (COT), Organisational Pride (OP), Work mindedness (WM), Civic Virtue (CV), Social and Functional Participation (SFP), Altruism (Al), Sportsman spirit (SS), Individual Initiative (II) and Generalised Compliance (GC).

It is a 6 point likert type scale as ranging from 1 (strongly disagree) to 6 (strongly agree). It has high reliability and high validity. The higher the score, the higher is the organisational citizenship behaviour is there in the employee.

Procedure

After establishing proper rapport with the subjects, they were handed over the questionnaires of both the measures. The confidentiality of information was also assured. After their completion of these questionnaires, both were taken back. After that item wise scoring was done for each subject as per the procedure laid down in the manual. Then the statistical analysis was done by using correlational and regression analysis.

RESULTS AND DISCUSSION

The objective of study was to explore the relationship between work stress and organisational citizenship behaviours in employees of call centers. The organisational citizenship behaviour was investigated in the light of eleven dimensions, i.e. ES, COR, COT, OP, WM, CM, SFP, Al, SS, II and GC. The job stress was studied in the light of one sum total score, i.e. JS. For all these parameters, the product moment co-efficient correlation was calculated.

Table No. 1

	JS	ES	COR	CT	OP	WM	CV	SFP	Al	SS	II	GC	OCB
JS	-	-.16*	-.32**	-.24**	-.21*	-.30**	.11	-.06	-.02	-.35**	-.12	-.03	-.20**

*p<.05, **p<.01

Table I clearly revealed that job stress has significant negative relationship with emotional support (-.16), concern for organisational resources (-.32), conservation of time (-.24), organisational pride (-.21), Work Mindedness (-.30), Civic Virtue (-.11), Social and Functional Participation (-.06), Altruism (-.02), Sportsman Spirits (-.35), Individual Initiative (-.12) and Generalised Compliance (-.12) and Overall OCB (-.20) respectively. Jain and Cooper (2012) investigated the direct effects of organisational stress and OCBs in Indian Business Process Outstanding Organisations. Negative relationship was found between these two variables. These findings are in congruence to our obtained findings. The present obtained findings can be interpreted in the lines of organisational role theory and social exchange theory. As we know that the construct of OCBs is multiconstruct and having number of dimensions. An individual in normal life has various virtues, i.e. inclination towards work, prosocial behaviour, compliance etc. But in call centers working since morning and till late evening creates lot of stress which hampers in the OCB that show indirectly make employees not in the good books of their managers. Their in-role behaviours are not taken appropriate. In conclusion, the need of an hour of today's organisations is to make stress free work set-up, so that the employees do co-operate at interpersonal level and enhance OCBs which would be fruitful for organisation's outcome.

Table No. 2 : Multiple correlation and % of variance accounted for OCB

Variable	Multiple R	R square
JS	-.321**	.103

As per the second objective, i.e. to study the role of job stress on the organisational citizenship behaviours, regression analysis was done. In this, job stress was the predictor and OCB was taken as criterion. The obtained beta value of -.321 was significant at .01 level of confidence. It shows significantly higher association between two constructs, i.e. job stress predicts OB negatively explaining 10% of variance.

LIMITATIONS

The study would have brought more meaningful results if the comparative analysis would have been made between males and females. Some more demographic variables would have been selected to make the study more fruitful.

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Altruistic Behavior and Inter-Personal Trust among Behavioral Sciences and Engineering Students

Nasrina Siddiqi[1], Sneha Mishra[1]*, M. Shafiq[2]

ABSTRACT

The purpose of the present investigation was to compare the levels of Inter-Personal Trust and Altruistic Behavior between Behavioral Sciences and Engineering students. Convenience sampling technique has been used to collect data from 100 college students studying in Jamia Millia Islamia University. Of these 100 students, 50 were from Behavioral Science stream (Sociology, Psychology, Political Science and Social Work) and the other 50 were engineering students. The two groups of students (Engineering and Behavioral Sciences students) were compared on the said variables namely, Inter-Personal Trust and Altruistic Behavior, using independent sample t-test. Results suggest that Students studying Behavioral Sciences and those studying engineering differ significantly in terms of Inter-Personal Trust and Altruistic behavior. Moreover, the mean values indicate that Behavioral science students tend to score higher on Altruism as well as Inter-Personal Trust as compared to engineering students.

Keywords: *Altruistic Behavior, Inter-Personal Trust, Behavioral Sciences*

The rise of behavioral sciences has brought a drastic change in how we conceptualize science. Today, science is something more than just a study of some concrete phenomenon which can be observed directly. Instead, it also entails the study of those abstract phenomenon, such as thinking, behavior, attitudes, society, interpersonal relations and so on, which cannot be observed directly through our senses. This whole shift from concrete to abstract, from brain to mind or from anatomy to individual led to the emergence of behavioral sciences. Today, disciplines such as psychology, sociology or anthropology etc. are viewed as sciences, though not core sciences but social or behavioral sciences. The emergence of behavioral sciences is a relatively recent development. A few decades ago, scientists did not acknowledge these disciplines as sciences. But today behavioral sciences are occupying a pivotal role in the area of research and are growing at a fast pace.

[1] Research Scholar, Department of Psychology, Jamia Millia Islamia, New Delhi
[2] Professor, Department of Psychology, Jamia Millia Islamia, New Delhi
*Responding Author

A review of literature reveals that there is a significant impact of academic majors on personality and, therefore, students of different academic majors possess different personality traits (Lievens, Coetsier, Fruyt & Maeseneer, 2002). Studying behavioral sciences, such as Sociology, Psychology, Political Science or Social Work etc., does not only give us a better understanding of ourselves and our surroundings but it also affects the way we look at things and how we interpret various social phenomenon. Therefore, Behavioral sciences impact the values, beliefs, perceptions, thinking and the overall personality of individuals.

The present investigation is an attempt to study how behavioral sciences contribute to social harmony. The two components of social harmony which have been looked into, include inter-personal trust and altruistic behavior. The study attempts to compare behavioral sciences and engineering students in terms of inter-personal trust and altruism to find out whether or not the two groups of students differ significantly on the said variables.

Interpersonal trust

Trust is a very important factor in human relations. Interpersonal trust plays an important role in holding relationships and it may also facilitate performance both at individual as well as group level. Mayer, Davis, and Schoorman (1995) conceptually defined trust as “A willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that party.” Trust has been operationalized in different ways by various thinkers and researchers. Specifically, most operational definitions examine trust as a belief about whether a partner is dependable (McAllister, 1995), cares for your interests (Cook & Wall, 1980), is competent (Mishra, 1993) and/or will act with integrity (Robinson, 1996). The importance of trust lies in the presence of this concept in Erikson’s and Allport’s personality theories. Rotter (1971), in his social relation theory, defines inter-personal trust as "one's generalized expectancy that another individual's word or promise can be relied on in the absence of contrary evidence". In a more recent definition, Deutsch (1973) associates trust with a positive feeling. He describes trust as "A confidence that one will find what is desired from another rather than what is feared. Scanzoni (1979) defines it as an actor's willingness to arrange and repose his or her activities on other because of confidence that other will provide expected gratifications". Apart from expectations from others trust requires to put oneself in a position of risk. Interpersonal trust may also be referred to as a set of assumptions towards others which are gradually developed through inferences from one’s experience about others.

Various studies have been conducted to analyze and investigate the interpersonal trust orientation. In one such study, it was found that male students are more trusting than female students. The same study also revealed that white students and students belonging to higher socio-economic class are more trusting than Black students and students of lower socio-economic class respectively (Terrell & Barrett, 1979). Zi Qiang and Zhang (2012) in their cross-temporal meta-analysis done from 1998 to 2009 of 53 papers revealed that Chinese college

students' interpersonal trust was declined significantly for both males and females. Results also showed that Interpersonal trust of students from rural area declined significantly, whereas trust of students from urban area remained constant. Apart from Race, sex and socio-economic status some studies have been conducted to explore the significance of educational background in predicting interpersonal trust orientation. Findings of Bisht (1986) showed that interpersonal trust of science undergraduate girls was significantly lower than that of the boys. Further, the interpersonal trust scores of arts students was found to be significantly higher than science students in this study. Iravani & Dindar (2011) in their study on university students found meaningful relationship between network variables, voluntary membership, activity, state of employment and generalized trust. Juan (2007) in his study on interpersonal trust found that students from education department scored higher than medical department students. Science department student scored lower than literature students. Moreover, interpersonal trust level of seniors was the highest and that of freshers was the lowest.

Altruism

Altruism has been conceptualized differently in different disciplines. The different aspect of altruism as well as its own definition lacks agreement among scholars. Despite the controversy, the most basic definition focuses on seeking the welfare of others. Wilson (1975) defined altruism as "Self destructive behavior performed for the benefit of others". Definitions of altruism in psychology focus on two factors: intentions and the amount of benefit or cost to the actor (Krebs, 1987). Bar Tal (1986) notes that, with few exceptions, most of those who emphasize the motivational aspect of altruism agree that: " altruistic behavior (a) must benefit another person, (b) must be performed voluntarily, (c) must be performed intentionally, (d) the benefit must be the goal by itself, and (e) must be performed without expecting any external reward."

Various studies have been conducted to explore the differences in level of altruism among different educational background and different occupation. Nestman (1991) in his study found that people working in social services and related areas have higher altruistic tendencies. In another study, Sawyer (1966) studied the differences of altruistic behavior of social sciences, business graduate, and social service (YMCA) students. Results revealed that the most altruistic group was social service students. Social service students helped everyone but business students helped themselves. Social science students helped who needed them. Haski-Leventhal, Cnaan, Handy et al. (2008) showed that students' vocational choice impacted their tendency to volunteer, more than other background factors, but that the way vocational choice impacted the tendency to volunteer varied in different countries and cultures.

Frey and Meier (2004) found in their study that people differ significantly in their pro-social attitudes. The choice of subjects influences one's pro-social attitude even when other characteristics, such as age and gender etc., are kept constant. The results of their study also suggest that students select different disciplines according to their pro-social preferences.

Codding and Steinberg (2004) found that social sciences students exhibit more altruistic behavior than natural sciences students.

In the light of above facts, the present study has been planned to explore the significance of behavioral sciences in facilitating social harmony. Interpersonal trust and altruistic behavior have been looked upon as variables of social harmony. Sample has been divided among behavioral sciences and engineering students to see the impact of educational background as contributing factor in social harmony. *With the help of the review, the following objectives were framed for the present study:*

- To compare the level of interpersonal trust among behavioral sciences and engineering students.
- To compare the level of altruism among behavioral sciences and engineering students.

On the basis of the above research objectives, following hypotheses were formulated:

H1**:** There will be a significant difference between Behavioral Sciences and Engineering students on inter-Personal trust.

H2: There will be a significant difference between Behavioral Sciences and Engineering students on Altruistic Behavior.

METHOD

Sample

The sample for the present study consisted of 100 students selected with the help of convenience sampling from Jamia Millia Islamia University, New Delhi. Out of these 100 students, 50 were behavioral sciences (such as Psychology, Sociology, Social Work and Political Science) students and the other 50 were engineering students. Therefore, two-group design was used in the present study. Each group included both, males as well as females in unequal proportion.

Tools

Interpersonal trust scale by Gupta and Mathur (1991) has been used to assess inter-personal trust. It consists of 20 items. The responses may range from “Totally disagree” (1) to “Totally agree” (4). Previous researches have shown that the split-half reliability of the scale ranges as high as 0.91.

Altruistic behavior has been measured with the help of Altruistic Personality Scale, developed by Rushton, Chrisjohn and Fekken (1981). It is a 20-item scale with responses ranging from Never (0) to Very Often (4). Previous studies show that the internal consistency of these 20 items is extremely high (α=0.89) along with high degree of validity and reliability (r=0.78).

RESULTS AND DISCUSSION

Table 1, Test of Normality for Behavioral Sciences and Engineering Students

Academic majors	Behavioral sciences			Engineering		
	Shapiro-Wilk test			Shapiro-Wilk test		
	Statistic	df	Sig.	Statistic	df	Sig.
Interpersonal trust	0.967	50	0.171	0.971	50	0.254
Altruism	0.974	50	0.344	0.958	50	0.075

In order to ascertain the normality of sample distribution, Shapiro-Wilk test was administered (table-1) which yielded statistically non-significant values for, both the groups. As a rule of thumb, a sampling distribution can be considered normal if only these values are statistically non-significant i.e. $p>0.05$ (Field, 2009). Since, in this case, the significance values for the two groups are greater than 0.05, we can safely conclude that the sample of the current study is normally distributed. After determining the normality of research sample, appropriate parametric statistical techniques were applied to further analyze the data.

Table 2, Results of t test and Descriptive Statistics for Interpersonal Trust

Variable	Academic Majors	N	Mean	S.D.	T	Cohen's d	1-β
Inter-Personal Trust	Behavioral Science Students	50	48.3	11.3	4.04**	0.81[#]	0.98
	Engineering Students	50	57.7	11.9			

*Significant at *0.05; **0.01 level*

[#]*0.2(small effect size), 0.5(medium effect size), 0.8 (large effect size)*

Since inter-personal trust scale consists of reverse items, low scores on this scale indicate high inter-Personal trust. Therefore, table-2, above, shows that behavioral sciences students score more on interpersonal trust (M=48.3, SD=11.3) than engineering students (M=57.7, SD=11.9), $t_{(49)}= 4.04$, $p<0.01$, d=0.81. Moreover, the power of test (1-β=0.98) has also been found to be above convention (0.8) which suggests that we can safely reject the null hypothesis stating that there is no significant difference between the two students' groups on interpersonal trust. Therefore, hypothesis 1 has been fully supported by findings of present investigation.

Although, a number of studies have been conducted on inter-Personal trust among college students but most of these studies have focused on gender differences or class differences in inter-Personal trust. And not much work has been done so far to identify the role of academic

choices in developing inter-personal trust among college-goers. These results, therefore, are novel for they indicate the important role of academic choices in developing inter-Personal trust and they also reveal, specifically, the significant role of behavioral sciences in developing inter-Personal trust in college students. A similar study was conducted by Bisht (1986), who compared the levels of inter-personal trust among arts and science students and found that the interpersonal trust scores of arts students were significantly higher than those of the science students. The results of the present investigation can be supported by the findings of this research to some extent.

Table 3, Results of t test and Descriptive Statistics for Altruistic Behavior

Variable	Academic Majors	N	Mean	S.D.	T	Cohen's d	1- β
Altruistic Behavior	Behavioral Science Students	50	54.2	10.5	2.22**	0.44#	0.61
	Engineering Students	50	48.8	13.5			

*Significant at *0.05; **0.01 level*

#0.2(small effect size), 0.5(medium effect size), 0.8 (large effect size)

Table-3 explicitly illustrates that behavioral sciences students are significantly higher on altruism (M=54.2, SD=10.5) as compared to those studying engineering (M=48.8, SD=13.5), $t_{(49)}$=2.22, p>0.01, d=0.44. Further, the power of test value (1- β= 0.61) has come out to be lower than convention. Therefore, hypothesis-2 has been fully supported by the findings of present research. These results have been supported by the findings of Nestman (1991) who found in his study that people working in the field of social sciences and other related areas have higheraltruistic tendencies.

Furthermore, the findings are also supported by the results obtained by Sawyer (1966) who compared students from social sciences, business studies and social services and found that students studying behavioral or social sciences are higher on altruistic behavior as compared to those from other academic majors. One's academic choice is important as it helps an individual in gaining knowledge through learning and innovation. Knowledge shapes one's perception and hence individuals from different academic majors understand societal needs and their role in it in unique ways. Behavioral sciences focus on human interaction which facilitates traits needed for better adjustment.

CONCLUSION

Thus, the findings of the present investigation, as shown in Table 1 and 2, reveal that behavioral sciences students and engineering students differ significantly from each other in terms of inter-personal trust (t=4.04) as well as altruistic behavior (t=2.22). Moreover, these results also

indicate that behavioral sciences students are higher on inter-Personal trust and altruistic behavior as compared to engineering students.

The limitation of present investigation lies in its small sample size. Further, the division of sample in two groups was based on academic choice. The basis of division would have suffered had attempts been made to equalize the number of participants in terms of gender across groups. Future researchers can take this into account and could conduct similar studies on larger samples with greater control over extraneous factors like gender and socio economic status. Despite these limitations, the findings of this investigation are very important in that they reveal the significant role played by academic choices in developing inter-personal trust and altruistic behavior and, consequently, in promoting and boosting social harmony. Therefore, the present research can be used as an empirical support for future researchers on which they can base their work.

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Rehabilitation of Fine Motor Coordination of Individuals with Chronic Alcohol Dependence

Neelu Sharma[1]*, Om Prakash[2], Sarika Alreja[3], K. S. Sengar[4], Amool R. Singh[5]

ABSTRACT

Long term alcohol abuse causes physical, cognitive, psychological and neuropsychological deficit in alcoholic individual. Current study intends assess and rehabilitate fine motor coordination of chronic alcohol dependent cases. Seven chronic cases of alcohol dependence were selected from de-addiction ward of Ranchi Institute of Neuropsychiatry and Allied Sciences, Kanke. All the cases were assessed on LNNB & AIIMS Motor function scale. Each patient was individually given one month rehabilitation training with Talking Pen. All the cases were assessed in pre and post test condition. Result was analyzed using Wilcoxin Sign Rank Test. Result reveals there was significant difference between patient's pre and post intervention performance which suggests improved fine motor functioning of the alcohol dependent individuals.

Keywords: *Rehabilitation, Chronic Alcohol Dependence, Fine Motor Coordination*

It is well known truth that alcohol abuse produces deficit in different functional areas of alcoholics. These deficits comprise dysfunction in attention, memory, thinking, problem solving including fine motor coordination and various cognitive, behavioral and social problems in due course of time. Persistent alcohol abuse results in a variety of neuropsychological abnormality such as regional brain structural damage (Sullivan 2000), and characteristic behavior motor deficit (Oscar et al, 2000). Significant impairment has been found on motor speed functions (Parks et al, 2003), muscle strength, and visual motor integration such as hand eye coordination (Tarter & Jones, 1971). Though neuropsychological functioning of alcoholic individuals have been studied widely, only a few studies have reported efficacy of rehabilitation program in motor dysfunction.

There is sufficient literature suggesting occurrence of motor dysfunction in alcoholic patients. The detoxified alcoholics tapped significantly slower than normal controls with each hand and

[1] Ph. D Scholar (Clinical Psychology) RINPAS, Kanke, Ranchi, India.
[2] Clinical Psychologist, GMCH, Department of Psychiatry, Chandigarh, India.
[3] Ph.D in Clinical Psychology.
[4] Additional Professor, Department of Clinical Psychology, RINPAS, Kanke, Ranchi, India.
[5] Professor& Head, Department of Clinical Psychology, RINPAS, Kanke, Ranchi, India.
*Responding Author

chronic alcoholic patients had impaired cognitive functions (Fals et al, 1994; Bates et al, 2002; Parks et al, 2003). However, till date very few studies have tried to remediate the fine motor functioning of alcoholic patients.

Alcohol consumption negatively effects physical and neuropsychological functioning of individuals who consume alcohol from a long period of time. It has been found in studies that chronic alcoholics confront impairment in specifically sustained and divided attention tasks, immediate effects on multiple cognitive-motor processing domains and decision-making, information processing, and judgment (Hindmarch et al, 1991; Moskowitz & Sharma 1974).

Here a question arises that whether these deficits are direct consequence of alcohol abuse. This question is difficult to answer and determine the effect of alcohol abuse on motor functioning of alcohol dependents. However, in present study we made some effort to deal with some of these issues. In current study the aims were to assess fine motor dysfunction and decipher the improvement in fine motor functioning of chronic alcohol dependence cases through fine motor rehabilitation techniques.

Alcoholics who either abstain from alcohol newly or from long time demonstrate deficit in learning and memory, abstraction and problem solving, and perceptual-motor skills (Oscar et al, 2000; Sullivan et al, 2000). Bilateral tremble and ataxia of the extremity are examples of motor dysfunction usually seen in alcoholic individuals when they discontinue drinking behavior (Welch et a., 1997; Sullivan et al, 2000, 2002). A number of researchers studied to know more about motor dysfunction in alcoholics, mainly because cerebellum is sensitive in alcohol related brain damage (Baker et al, 1999; Parks et al, 2002).

Previous researches demonstrate that some alcohol-dependent patients show disturbances of gait and posture (Sullivan et al, 2002). During abstinence or withdrawal period deficits in gait and posture persist (Sullivan et al, 2002). There is disagreement among researchers on the execution of small synchronized motor movement in upper limb. Some researchers states that abstinent alcoholics perform poor on the complex motor tasks than non alcoholic individuals (Fama et al, 2007; Parks et al, 2003; Sullivan et al, 2002). However, other researchers says that sober alcoholics and healthy controls perform equally well on these complex motor tasks (Sullivan et al, 2000).

The present study has tried to focusing the areas which has often overlooked and very less studied. It has been an attempt to understand nature and severity of fine motor deficit in chronic alcoholic patients and rehabilitate these deficits with the remediation training.

METHODS AND MATERIALS

Aims

- To assess the level of deficit in Fine Motor Coordination of Individuals with Chronic Alcohol Dependence
- To remediate Fine Motor Coordination of Individuals with Chronic Alcohol Dependence

Design

This study was a center based confirmatory study using individual case study: pre and post test design.

Venue

Drug De-addiction unit of Ranchi Institute of Neuropsychiatry and Allied Sciences, Kanke, Ranchi, Jharkhand, India

Sample

Seven male patients of the age group 30-45years, right handed ,educated up to matriculation, employed/ unemployed belonging to middle/lower socioeconomic status of rural and urban background of Jharkhand and Bihar, having a history of approximately 10 years of alcohol intake, presently admitted in drug de-addiction ward of RINPAS were taken using purposive sampling. All the participants fulfilled the ICD-10 criteria for alcohol dependence. Any other co-morbid psychiatric/neurological/major physical illness was ruled out. Patients were given the informed consent for the study.

Inclusion Criteria

- Male patients
- Age range 30-45 years
- Right handed.
- History of alcohol intake for at least 10 years with dependence pattern for at least 3 years
- Abstinent period of minimum three weeks following detoxification phase
- At least 10 years of Schooling
- Patient who gave consent for the study

Exclusion Criterion

Patients with any co-morbid conditions
Family history of mental illness
Uncooperative patients

Tools for the Assessment

- SOCIO DEMOGRAPHIC & CLINICAL DATA SHEET

This is semi structural Performa especially drafted for this study. It contains information about the socio demographic variables like–age, sex, education, marital status, religion, occupation, socio-economic status & domicile of the subject. It also includes the clinical details like-diagnosis, age of onset, total duration of illness, and history of alcohol or substance abuse, family history of mental illness, any history of significant head injury, seizure, mental retardation and any other significant physical or psychiatric illness.

- SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE FORM- C (SADQ-C) (STOCK WELL ET AL, 1994)

The Severity of Alcohol Dependence Questionnaire is a 20-item questionnaire designed to measure the severity of alcohol dependence.

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence.

The severity rating for the each 20 item is based on the subjective report of the patient about his/her condition. Answers to each question are rated on a four-point scale: Almost never – 0, sometimes 1, often 2, nearly always and 3. A score of 31 or higher indicates "Severe Alcohol Dependence". A score of 16 -30 indicates "Moderate Dependence" and a score of below 16 usually indicates only a mild physical dependency.

- HAND PREFERENCE BATTERY

This scale is constructed by Annett (1970) and published in British Journal of Psychology, volume 61. It has six items. Based on this scale dominant hemisphere is ascertained.

- AIIMS COMPREHENSIVE NEUROPSYCHOLOGICAL BATTERY ADULT FORM – MOTOR FUNCTION SCALE (GUPTA ET AL, 2000)

The AIIMS Comprehensive Neuropsychological Battery is potentially useful for both diagnosis and rehabilitation. It is a standardized neuropsychological battery for a wide variety of patients with varying deficits. The battery has a further benefit of requiring a relatively short administration time. The 160 items in Hindi of the test are spread over 10 primary scales which are as follow: Motor scale, Tactile scale, Visual scale, Receptive speech, Expressive speech, Reading scale, Writing scale, Arithmetic scale, Memory scale, and Intellectual process scale. It is a 5 point rating scale from 0-4 where 0 shows no brain damage, scores 1, 2, and 3 suggest intermediate performance and score 4 indicating brain damaged performance.

- LURIA NEBRASKA NEUROPSYCHOLOGICAL BATTERY GOLDEN ET AL 1985(FORM-I, MOTOR FUNCTION SCALE)

Luria Nebraska Neuropsychological Battery Form-I (Golden et al., 1985) has eleven sub scales Motor scale, Rhythm scale, Tactile scale, Visual function scale, Receptive speech, Expressive speech, Reading scale, Writing scale, Arithmetic scale, Memory scale, and Intellectual process scale. Motor function scale is longest scale on the battery consists 51 items and one of the most useful scale. As the first scale, it includes initial items which is very easy and which most clients are capable of doing.

- THE TALKING PEN (WAYNE ENGINEERING, 1974)

Since 1974 the Talking Pen has been the premier instrument for developing fine-motor skills through pattern tracing. The Talking Pen is a proven tool for developing perceptual-motor skills from basic diagnostics to advanced training. Although applications are almost unlimited, it is most often used to diagnose and develop gross and fine motor skills, hand-eye coordination, laterality, directionality, auditory perception, form perception, ocular pursuits and spatial relationships. It has been used successfully with the learning disabled, the visually impaired, the brain injured, the hyperactive and the dysgraphic individual.

Tool for Intervention

- THE TALKING PEN

The pen is triangular shaped and easy to hold and operate. Individual can grasp writing the pen like any writing tool with the thumb, index finger and middle finger Individual should hold the pen at no less than a 45 angle from the writing space.

An infra-red light and fiber optic sensor in the tip of the pen sense reflect as the user traces a pattern with the pen and provide immediate auditory feedback if the user wanders off the pattern. The pen is quiet when the tip is on a black image and emits a buzz when the tip is on a white surface.

The aim of the intervention was to rehabilitate the fine motor coordination of the alcohol dependence cases which was deteriorated due to chronic alcohol dependence. Therefore 6 exercises out of eight exercises of Talking Pen were applied with the each patient individually.

Procedure

All the participants were selected according to inclusion & exclusion criteria. Socio-demographic and clinical information was collected by using the Socio demographic & Clinical Data Sheet. Hand Preference Battery was administered to ascertain the handedness of the patients. SADQ-C was done to assess the severity of alcohol dependence of the patients (only cases who had scored more than 31 or above on SADQ-C were selected for the study). All the patients were trained individually with the help of the Talking Pen everyday for 30 minutes for a period of one month and pre and post training performance was assessed. The motor function scales of the All India Institute of Medical Science Comprehensive Neuropsychological Battery. (AIIMSCNB)& Motor functions scale of the Luria Nebraska Neuropsychological Battery (LNNB: Form-I) was also administered to each participant individually pre and post intervention condition to assess the status of motor functions.

Statistical Analysis

Data was entered, coded and statistically Analyzed by applying Wilcoxin Sign Rank test to find difference in pre intervention and post intervention condition. Percentage was also used to show the sociodemographic details of the patients.

RESULT

Table: 1 reveals Sociodemographic characteristics of alcohol dependent individuals. Only male patients were included in the study. Most of patients were between the ages of 30 to 40 years. Majority of the cases were educated up to matriculation (57%) ,majority of the cases (58%) were Christian followed by Hindu (42%) , majority of cases were belonging to urban area (71%) followed by rural (29%), majority of cases were employed (71%), married (57%) and showing history of chronic alcohol dependence (since 10 years).

Table: 2 show performance of patients on Motor Function Scale of LNNB & AIIMS Comprehensive Battery.

On LNNB in pre intervention assessment Mean ± SD = 24.00 ± 7.81 and post intervention assessment it was 11.71 ± 2.49, Z score = 2.37. Difference between pre and post intervention assessment was significant on .01, suggests significant difference in pre and post test performance of the cases.

On AIIMS Battery in pre intervention assessment Mean ± SD = 56.71 ± 8.59 and post intervention assessment it was 41.28 ± 2.92, Z score = 2.37. Difference between pre and post intervention assessment was significant on .01

Table: 3 shows baseline assessment and post intervention assessment of performance of all the seven cases individually on Talking Pen. Six exercises i.e. Eye Hand Coordination, Cognitive Motor Skill, Cross Line Directionality, Basic Graphic Motor Skill, Cursive Writing Skill and Manuscript Skill were assessed and rehabilitate with the help of Talking Pen. Assessment was done in terms of number of errors done on each exercise and time (in seconds) taken in completion of exercise. All the seven cases were assessed individually on each exercise in pre and post intervention settings. This table also demonstrates that all the seven patients took more time and did more errors in pre test condition on all the exercises. After one month intervention (each patient individually) there were marked decreased in time and errors done by the patients on all exercises of Talking Pen. Thus the table reveals that significant improvement occurred in performance of the Subjects which indicates towards improved fine motor coordination.

Table. 1 Showing Sociodemographic Characteristics of all the seven Alcohol Dependent Cases

Age	30- 40 yrs	68.%
	41- 45yrs	32%
Duration	10 yrs	70%
	11-15 yrs	30%
Sex	Male	100%
Education.	Metric	57%
	Intermediate	43%
Occupation.	Unemployed	29%
	Employed	71%
Marital status	Unmarried	43%
	Married	57%
Religion.	Hindu	42%
	Christian	58%
Domicile	Rural	29%
	Urban	71%
S.E.S	Lower SES	58%
	Middle	42%

Table 2 showing patients pre & post intervention performance on LNNB & AIIMSCNB of all seven cases

Assessment	Pre intervention assessment Mean±SD	Post intervention assessment Mean±SD	Wilcoxin sign rank test		
			Sign	Mean Rank	Z score
LNNB	24±7.81	11.71±2.49	+	.00	2.37**
			_	7.00	
AIIMS	56.71±8.59	41.28±2.92	+	.00	2.37**
			_	7.00	

** p ≤.01 level of significance

Table 3 showing patient's pre and post intervention performance on Talking Pen regarding time & errors

Assessment			Variables						M± SD	Wilcoxin sign rank test		Z score
			Eye Hand co.	Cog. Mo. skill	Directionality	Basic Gr. skill	Cur. Writing	Manuscript		Rank	MR	
Case 1	Time	Pre	142	48	117	253	245	98	150.50±82.33	+	.00	2.201*
		Post	113	34	99	145	102	40	88.85±43.37	_	3.50	
	Error	Pre	1	2	6	25	9	7	9.33±5.71	+	.00	2.207*
		Post	0	1	4	6	3	2	2.66±2.16	_	3.50	
Case 2	Time	Pre	747	309	428	458	224	200	394.33 ±201.80	+	.00	2.201*
		Post	271	102	302	451	126	60	218.66±149.02	_	3.50	
	Error	Pre	11	2	1	5	5	15	6.50±5.43	+	.00	1.892*
		Post	5	1	0	2	6	6	3.33±2.43	_	3.50	

Case 3	Time	Pre	291	95	153	436	357	75	222.50±145.96	+	.00	2.201*
		Post	90	49	79	212	188	40	109.67±72.75	_	3.50	
	Error	Pre	6	5	9	11	19	8	9.66±5.04	+	.00	2.201*
		Post	3	2	2	4	6	2	3.16±1.46	_	3.90	
Case 4	Time	Pre	304	65	135	360	305	70	206.65±131.55	+	.00	2.201*
		Post	203	35	88	150	140	30	107.67±68.73	_	3.50	
	Error	Pre	9	0	4	12	13	10	8.00±5.01	+	.00	2.023*
		Post	2	0	1	3	4	4	2.33±1.52	_	3.00	
Case 5	Time	Pre	214	68	169	268	191	110	170.00±72.09	+	.00	2.207*
		Post	151	52	154	192	128	128	129.50±48.67	-	3.50	
	Error	Pre	12	0	10	8	7	12	8.16±4.49	+	.00	2.041*
		Post	4	0	4	2	0	4	2.33±1.96	-	3.00	
Case 6	Time	Pre	202	71	98	205	167	123	144.33±55.67	+	.00	2.201*
		Post	170	48	35	150	90	75	94.66±54.55	-	3.50	
	Error	Pre	8	7	6	13	10	6	8.33±2.73	+	.00	2.207*
		Post	2	3	0	6	2	3	2.66±1.96	-	3.50	
Case 7	Time	Pre	304	85	130	369	309	80	212.83±128.68	+	.00	2.207*
		Post	203	35	88	150	140	30	107.67±68.73	-	3.50	
	Error	Pre	9	0	4	12	13	10	8.00±1.16	+	.00	2.203*
		Post	2	0	1	0	0	4	3.00±2.16	-	3.00	

* $p \leq .05$ level of significance

Table-4 Showing Qualitative Analysis of Neuropsychological Performance at Baseline and after Intervention of all the seven patients on LNNB

Functions	**No. of patients impaired on the Motor Functions Scale**	
C1 (Motor Functions)	**At Baseline**	**After Intervention**
Simple movement of hand	0	0
Kinesthetic movement of hand	4	2
Optic spatial organization	6	1
• One plane	3	0
• Double plane	2	1
• Verbal command	4	2
• Midline	3	0
Smooth coordination of hand movement	3	2
Complete forms of praxis	4	1
Simple movement of oral area	0	0
Smooth coordination of oral movement	2	0
Oral praxis	2	0
Selectivity of motor act	4	2
• Form	5	0
• Speed	4	1
Verbal regulation of motor act	3	0

Table-4 **s**hows qualitative analysis of patients' neuropsychological performance at baseline and after intervention. The qualitative analysis of the neuropsychological performance reveals that patient's neuropsychological performance was markedly improved after intervention.

DISCUSSION

The present study was conceptualized to rehabilitate the fine motor coordination of chronic cases with alcohol dependence. The neuropsychological test was chosen to assess the motor dysfunction in alcoholic patients, because they are standardized, well known measures which can be scored reliably and have proven sensitive to frontal lobe dysfunction. The Talking Pen was chosen as intervention tool because it is a primary measure to improve fine motor coordination since its development.

Findings of the current study demonstrates that all seven patient's scores on Motor Functions Scale of LNNB & AIIMS Comprehensive Battery(AIIMSCB Motor Function Scale), were more in pre test condition and it was markedly reduced after the intervention with the help of Talking Pen. The findings also suggest that there was significant improvement in patient's fine motor coordination after pattern tracing practice. Findings of the present study is consistent with

previously done studies recommends pattern tracing is useful technique to remediate fine motor skill (Victor et al, 1989).

Our study is in agreement with the previous findings, reports that abstinence alcoholic shows impaired cognitive and motor functioning than the healthy controls (Biederman, 1991; Sullivan et al, 2002). Findings of some researchers conclude that abstinence alcoholic performs worse on the complex motor task than healthy controls (Fama et al, 2007). Result of our study reveals that the impaired motor functioning in chronic cases with alcohol dependence was significantly remediated through Talking Pen in one month remediation program. It is apparent from the table 3 that the eye hand coordination, cognitive motor skill, basic graphic motor skill, directionality, manuscript ability was significantly improved as there is significant reduction in time taken and errors done by the patients in completion of task (exercises of Talking Pen) after rehabilitation program.

Fine motor impairment of chronic alcohol dependent patient can be remediate with different behavioral, cognitive and neuropsychological rehabilitation programs and it was found to be proved in past literature as well as in the current study. Gorden et al., (1988) have shown neuropsychologically impaired alcoholics who had deficit in reasoning ability, visuospatial ability, visuomotor ability and learning and memory were improved after rehabilitation training program. Previous studies demonstrate that motor dysfunction in alcoholics with co morbid condition was more severe than alone alcohol dependence (Fama et al, 2007). Thus the present study has also tried to eliminate other co morbidities by ruling out any other co morbid psychiatry/ physical condition with alcohol dependence and focus specifically on rehabilitation of fine motor coordination.

However, findings of current study is somewhat inconsistent with the findings of some previously done researches which states that fine motor deficits of alcohol abstain individuals recovers by the time gap (Reed et al, 1992). This discrepancy may be due to methodological differences between current and past studies. Our study is a small sample study and it was only planned with the chronic alcohol dependent cases with severe alcohol dependence which needs medical as well as psychotherapeutic/instrument intervention.

Hence, the result of the present study is very encouraging for all those mental health professionals who are interested in the study of fine motor rehabilitation of alcoholic patients.

CONCLUSION

The result of the study suggest that chronic alcohol abuse has a destructive effect on fine motor functions and these dysfunction can be improve with the help of neuropsychological and fine motor remediation techniques which involves repetitive training and exercise. Hence, along with pharmacotherapy cognitive/fine motor remediation therapy would be helpful in the treatment of

alcohol related motor problems. This study will have important implication in a daily function as well in professional function.

LIMITATIONS

Small sample size was a limitation of the present study. Since it was a pre and post test intervention study done individually with each patient who were in the state of abstinence, hence a control group was not included in study. Further a control group can be taken to make a comparison. The female population was excluded from the study thus limiting its generalization.

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Psychosocial Adjustment among Orphan Children Living with HIV/AIDS

Sampathkumar[1], Ravikumar, M. B.[2]*, Manjunatha, P.[3], Surma, S.[3]

ABSTRACT

AIDS is the final stage of infection with the retro-virus HIV. This disease not only affects the individuals' physical health, but it also affects the psychological health and the adjustment of an individual towards oneself and his surrounding environment. The objective of the present study is to understand the level of psychosocial adjustment among orphan and non-orphan children living with HIV/AIDS. Adjustment inventory was administered to 400 orphan and non-orphan children living with HIV/AIDS. Results indicated that orphan children with HIV/AIDS were having lower level of adjustment than non-orphan children with HIV/AIDS. Within the orphan children with HIV/AIDS the girl and rural children were having lower level adjustment compared to the boy and urban children. The study suggested the need for specific interventions to improve adjustment of the orphan children with HIV/AIDS.

Keywords: *Adjustment, Orphan HIV/AIDS children, HIV/AIDS Children.*

An orphan child is defined as a person who has lost one or both parents (United Nations Children Education Fund (UNICEF), 2004). The death of a parent during childhood is traumatic, with a profound and potentially lasting impact on a child's psychosocial wellbeing (Li et al., 2008). In addition to the developmental vulnerability normally faced by any child whose parents have died, experience with parental illness and death due to Acquired Immune-Deficiency Syndrome (AIDS) may create additional cognitive and social challenges. These challenges may further aggravate the grieving process among children who have lost parents or who face the potential of losing parents to AIDS, and may increase risk for psychosocial adjustment problems.

The Human Immunodeficiency Virus (HIV) and AIDS researchers have projected an estimated 65 million deaths from AIDS by the year 2020; more than triple the number who died in the first 20 years of the epidemic unless major efforts are put toward primary prevention or major

[1] Assistant Professor, Department of Studies in Psychology, University of Mysore, Mysuru -570 006, Karnataka, India.
[2] Counsellor, ART Centre, Mandya Institute of Medical Sciences, Mandya, Karnataka, India.
[3] Assistant Professor, Department of Studies in Psychology, Karnataka State Open University, Mysuru -570 006, Karnataka, India.
*Responding Author

developments in treatment take place (Altman, 2002). According to National Aids Control Organization (NACO) report 2009-10, India has 2.27 million HIV-infected persons, the third highest in the world after South Africa and Nigeria. The Karnataka State Aids Prevention Society's (KSAPS) Consolidated ART report July 2012, the scenario of Karnataka state is 0.223 million adult and 0.016 million children are registered for Anti Retroviral Therapy (ART).

AIDS is the final stage of infection with the retro-virus HIV. This virus gradually impairs the immune system which is crucial for the suppression of infections, viruses and bacteria. As the immune systems weakens, HIV infected person becomes infected with opportunistic infections. HIV/AIDS is a chronic disease and without treatment persons will eventually die. According to Tate et al. (2003), the new advances for treatment of HIV using Highly Active Antiretroviral Therapy (HAART) have dramatically improved disease prognosis.

Antiretroviral therapy (ART) in children preserves or restores immune function; provides sustained suppression of the viral load; promotes or restores normal growth and development; improves the quality of life; prevents complicating infections and cancers; and prolongs the child's life. Yet an outright cure remains elusive, leaving persons with the challenges of living with a chronic medical condition. Orphan children with HIV positive can live a longer life because of medical advances like ART, but treatment programs have not been able to eradicate the virus and cure the disease. As a result, orphan children are living longer with a chronic condition that continuously presents physical, psychological and social challenges. Like all patients with chronic medical disorders, HIV-infected children also are at increased risk for specific psychiatric and psycho-social adjustment problems.

Adjustment

The term adjustment is often used as a synonym for accommodation and adaptation. Strictly speaking, the term denotes that the results of equilibrium, which may be affected by either of these processes (Monroe, 1990). It is used to emphasize the individual's struggle to get along or survive in his or her social and physical environment. Several factors are thought to influence the psychosocial adjustment of orphan children born with HIV infection.

These factors include (a) the presence of HIV in the central nervous system during fetal development and throughout childhood, (b) co-occurring medical conditions and complications of HIV disease, including body image issues, (c) teratogenic effects of drug and alcohol during the prenatal period, (d) cognitive and neurological deficits, (e) other psychosocial factors (maternal illness, multiple separations, transitions, and losses), (f) whether the child knows his or her HIV status and (g) environmental factors (Brown et al., 2000; Gaughan et al., 2004; Lwin and Melvin, 2001; Mellins et al., 2003). Environmental factors affecting families living with HIV include poverty, violence, racism, overcrowding, single-parent households (Armistead and Forehand, 1995). Such factors also would likely increase the risk of psycho-social adjustmental problems in orphan children living with HIV/AIDS.

Orphan children living with HIV/AIDS are considered as highly deprived class of society. These children are left helpless, abandoned, neglected by the parents/ caregivers due to social, economic and personal reasons like gender, domicile, age, etc. They are deprived of one or more necessities of life. Early separation from parents, deprivation of parental care, love, affection, warmth, security, acceptance and discipline during childhood disrupts their normal educational development resulting in adjustmental problems. Makame, Ani and McGregor (2002) found that orphans had increased internalizing problems compared with non-orphans. In Ethiopia, Bhargava (2005) found that Children orphaned by AIDS showed more emotional and social adjustment problems, and girls reported higher levels of difficulties than boys. Atwine et al. (2005) found that rural orphans were more likely to be anxious, depressed and to display anger, showed significantly higher scores for feelings of hopelessness and suicidal ideation.

A study in Uganda had observed also girls with HIV/AIDS have lower education adjustment, knowledge, self-confidence and self-esteem (FAWE, 2000). However, it was also observed that school drop-out rates were higher among females students (7.6%) compared to males (6%) in Uganda (Baguma and Muhanguzi, 2000). Most of the reasons for female school dropout were due to family socio-cultural reasons including illness of parents due to HIV/AIDS or orphan hood due to HIV/AIDS or other causes (Baguma and Muhanguzi, 2000). Other sociocultural reasons included the gender inequality accorded to girls (Uganda Bureau of statistics, 2006). Boys were generally provided with the opportunities to continue with their education uninterrupted, while girls were usually requested by their families to stay at home to continue providing household services in the event of illnesses or demise of their parents (Baguma and Muhanguzi, 2000; Uganda Bureau of Statistics, 2006). It should be noted here that, orphan hood due to HIV/AIDS has been one of the greatest effects of HIV/AIDS on school girls' education in Africa leading to school absenteeism during their parents' illnesses and emotional stress manifested in inappropriate behavior (Baggaley and Needham, 1997; Yun, 2001; Wahl, 2001). Therefore, based on these supporting findings, it can be said that the emotional support within the fostering family will play a crucial role in the development of children.

So it becomes necessary to know whether HIV infected children who are devoid of family life with the emotional warmth grow up normally? How well they are able to cope with themselves and adjust to the demands of the environment/society around them? In this context the present study attempts to know the level of psychosocial adjustment of orphan children living with HIV/AIDS. Outcome of investigation will provide the way and need for appropriate counselling, guidance, care and support to overcome their adjustment problems.

OBJECTIVES

1. To study the level of social, emotional and educational adjustment of the orphan and non-orphan children living with HIV/AIDS.
2. To study the gender differences in social, emotional and educational adjustment of the orphan children living with HIV/AIDS.

3. To study the domicile differences in social, emotional and educational adjustment of the orphan children living with HIV/AIDS.
4. To study the interaction effects of gender and domicile on adjustment problems of the orphan children living with HIV/AIDS.

METHOD

Hypotheses

H_1: The orphan children with HIV/AIDS have lower social, emotional and educational adjustment than the non-orphan children with HIV/AIDS.

H_2: The orphan girls with HIV/AIDS have lower social, emotional and educational adjustment than the orphan boys with HIV/AIDS.

H_3: The orphan rural children with HIV/AIDS have lower social, emotional and educational adjustment than the orphan urban children with HIV/AIDS.

H_4: There is an interaction effect between gender and domicile on social, emotional and educational adjustment of the orphan children with HIV/AIDS.

Participants*:*

The participant group consists of total 400 children with HIV/AIDS, 200 were orphan and another 200 were non-orphan. Participants were selected from Paediatric ART Centre, Indira Gandhi Institute of child Health (IGICH), Bangalore. The participants' age ranges from 9 to 14 years and the mean age was 11.5 years.

Measure

Adjustment inventory: Developed by Sinha and Singh (1993) was adopted for this study. It consists of 60 items which measure adjustment in three different areas namely social adjustment, emotional adjustment and educational adjustment with 20 items each. The higher score indicates the lower adjustment. The test-retest reliability for 0.93 and the split-half reliability for 0.95 these values found to be highly significant and satisfactory.

Procedure*:*

The Participants were given appropriate instructions and administered the Adjustment Inventory in the group of 10 members. They were also asked to give their socio-demographic details in the prescribed profarma. They have to indicate their responses in the answer sheets given to them. Data collection was done in 40 sessions and a session lasted about 45-60 minutes approximately. The data was scored and statistically analysed by using descriptive statistics, independent t-test and Two-way ANOVA techniques.

RESULTS AND DISCUSSION

Table 1: shows the mean, SD and t values for psychosocial adjustment of the orphan and the non-orphan children living with HIV/AIDS.

DOMAINS	SOURCE OF VARIATIONS	N	MEAN	SD	t	P
Social	Orphan	200	12.53	1.835	3.117	.002
	Non-orphan	200	11.96	1.790		
Emotional	Orphan	200	14.68	1.701	3.219	.001
	Non-orphan	200	14.11	1.869		
Educational	Orphan	200	13.33	1.818	4.948	.001
	Non-orphan	200	12.43	1.820		
Total	Orphan	200	40.47	3.995	4.757	.001
	Non-orphan	200	38.48	4.364		

Table 1: shows the mean SD and t values for psychosocial adjustment of the orphan and the non-orphan children living with HIV/AIDS. On social adjustment the orphan children (Mean=12.53; SD= 1.835) scored higher than the non-orphan children (Mean=11.96; SD=1.790) and t value (3.117; p<.002) indicating a high significant difference. The orphan children were having significantly lower adjustment than the non-orphan children in social adjustment. On emotional adjustment the orphan children (Mean=14.68; SD= 1.701) scored higher than the non-orphan children (Mean=14.11; SD=1.869) and the t value (3.219; p<.001) indicating a high significant difference. The orphan children were having significantly lower adjustment than the non-orphan children in emotional adjustment. On educational adjustment the orphan children (Mean=13.33; SD= 1.818) scored higher than the non-orphan children (Mean=12.43; SD=1.820) and the t value (4.948; p<.001) indicating a high significant difference. The orphan children were having significantly lower adjustment than the non-orphan children in educational adjustment.

On the overall adjustment the orphan children (Mean=40.47; SD= 3.995) scored higher than the non-orphan children (Mean=38.48; SD=4.364) and the t value (4.948; p<.001) indicating a high significant difference. The orphan children were having significantly lower adjustment than the non-orphan children in overall adjustment. Therefore, the formulated $\mathbf{H_1}$; the orphan children with HIV/AIDS have lower social, emotional and educational adjustment than the non-orphan children with HIV/AIDS, is accepted.

Table 2: shows the mean, SD and F values for Social Adjustment of boys/girls and rural/urban orphan children with HIV/AIDS.

VARIABLES	SOURCE OF VARIATIONS	N	MEAN	SD	F	p
Gender	Boys	100	12.01	1.654	18.886	.001
	Girls	100	13.04	1.869		
Domicile	Rural	100	13.18	1.844	31.813	.001
	Urban	100	11.87	1.581		
Interaction	Gender*Domicile	200	12.53	1.835	15.583	.001

Table 2: shows the mean, SD and F values for social adjustment of boys/girls and rural/urban orphan children with HIV/AIDS. On the social adjustment the orphan girls (Mean=13.04; SD= 1.869) scored higher than the orphan boys (Mean=12.01; SD=1.654) and the F value (18.886; p<.001) indicating a high significant difference. The orphan girls were significantly lower than the orphan boys in social adjustment. Again on the social adjustment the rural orphan children (Mean=13.18; SD= 1.844) scored higher than the urban orphan children (Mean=11.87; SD=1.581) and the F value (31.813; p<.001) indicating a high significant difference. The rural orphan children were significantly lower than the urban orphan children in social adjustment. The interaction effect between gender and domicile on social adjustment (F=15.583; p<.001) is also found to be highly significant.

Table 3: shows the mean, SD and F values for Emotional Adjustment of boys/girls and rural/urban orphan children with HIV/AIDS.

VARIABLES	SOURCE OF VARIATIONS	N	MEAN	SD	F	P
Gender	Boys	100	14.07	1.754	29.008	.001
	Girls	100	15.29	1.409		
Domicile	Rural	100	14.97	1.749	5.715	.018
	Urban	100	14.39	1.607		
Interaction	Gender*Domicile	200	14.68	1.701	.931	.336

Table 3: shows the mean SD and F values for emotional adjustment of boys/girls and rural/urban orphan children with HIV/AIDS. On the emotional adjustment the orphan girls (Mean=15.29; SD= 1.409) scored higher than the orphan boys (Mean=14.07; SD=1.754) and the F value (29.008; p<.001) indicating a high significant difference. The orphan girls were significantly lower than the orphan boys in emotional adjustment. On the emotional adjustment the rural orphan children (Mean=14.97; SD= 1.749) scored higher than the urban orphan children (Mean=14.39; SD=1.607) and the F value (5.715; p<.018) indicating a high significant difference. The rural orphan children were significantly lower than the urban orphan children in emotional adjustment. The interaction effect between gender and domicile on emotional adjustment (F=.931; p<.336) is found non-significant.

Table 4: shows the mean, SD and F values for educational adjustment of boys/girls and rural/urban orphan children with HIV/AIDS.

VARIABLES	SOURCE OF VARIATIONS	N	MEAN	SD	F	P
Gender	Boys	100	13.26	1.685	.153	.696
	Girls	100	13.39	1.948		
Domicile	Rural	100	13.78	1.967	14.313	.001
	Urban	100	12.87	1.535		
Interaction	Gender*Domicile	200	13.32	1.818	19.055	.001

Table 4: shows the mean SD and F values for educational adjustment of boys/girls and rural/urban of orphan children with HIV/AIDS. On the educational adjustment the orphan girls (Mean=13.39; SD= 1.948) scored slightly higher than the orphan boys (Mean=13.26; SD=1.685) and the F value (0.153; p>.696) indicating a non-significant difference. The orphan girls and boys were statistically not having any difference in educational adjustment. On the educational adjustment the rural orphan children (Mean=13.78; SD= 1.967) scored higher than the urban orphan children (Mean=12.87; SD=1.535) and the F value (14.313; p<.001) indicating a high significant difference. The rural orphan children were significantly lower than the urban orphan children in educational adjustment. The interaction effect between gender and domicile on educational adjustment (F=19.055; p<.001) were highly significant.

Table 5: shows the mean, SD and F values for Overall Adjustment of boys/girls and rural/urban orphan children with HIV/AIDS.

VARIABLES	SOURCE OF VARIATIONS	N	MEAN	SD	F	P
Gender	Boys	100	39.22	3.609	23.814	.001
	Girls	100	41.72	3.988		
Domicile	Rural	100	41.81	4.498	27.686	.001
	Urban	100	39.13	2.866		
Interaction	Gender*Domicile	200	40.47	3.995	14.118	.001

Table 5: shows the mean SD and F values for overall adjustment of boys/girls and rural/urban orphan children with HIV/AIDS. On the overall adjustment the orphan girls (Mean=41.72; SD= 3.988) scored higher than the orphan boys (Mean=39.22; SD=3.609) and the F value (23.814; p<.001) indicating a high significant difference. The orphan girls were significantly lower than the orphan boys in overall adjustment. Therefore, the formulated $\mathbf{H_2}$, the orphan girls with HIV/AIDS have lower social, emotional and educational adjustment than the orphan boys with HIV/AIDS, is accepted.

On the overall adjustment of orphan rural children (Mean=41.81; SD= 4.498) scored higher than the orphan urban children (Mean=39.13; SD=2.866) and the F value (27.686; p<.001) indicating a high significant difference. The orphan rural children were significantly lower than the orphan urban children in overall adjustment. Therefore, the formulated $\mathbf{H_3}$ the orphan rural children with HIV/AIDS have lower social, emotional and educational adjustment than the orphan urban children with HIV/AIDS, is accepted. The interaction effect between gender and domicile on overall adjustment (F=14.118; p<.001) were highly significant. Therefore, the formulated $\mathbf{H_4}$; there is an interaction effect between gender and domicile on social, emotional and educational adjustment of the orphan children with HIV/AIDS, is accepted.

The overall result indicates that the orphan children have lower social, emotional and educational adjustment than the non-orphan children living with HIV/AIDS. When we consider only orphan

children, girl and orphan rural children have lower social and emotional adjustment than their counter parts boy and orphan urban children.

Under the circumstances where the family atmosphere is unhealthy, institutional care is the best available alternative for children living with HIV/AIDS. However a stable, reliable and understanding relationship does not depend primarily on words but on consistent response to child's feelings which gradually develops foundations of trust, confidence, and sense of security. This provides strong base from which they develop self identity, self respect, a sense of confidence and work. The Government and Non Government Institutions, Social Scientists should focus their attention to these children and families as they struggle to cope with this devastating disease. The present study suggests that the need for intervention targeting towards orphaned children to restore their optimum level of functioning and preventing them from maladjustment.

CONCLUSIONS

1. The orphan children with HIV/AIDS have a lower social, emotional and educational adjustment than non-orphan children with HIV/AIDS.
2. Girl and rural orphan children with HIV/AIDS have lower social and emotional adjustment than boy and urban orphan children with HIV/AIDS.
3. There is no gender difference in educational adjustment of orphan children with HIV/AIDS.

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Assessment of Shyness among Tribal and Rural Adolescents and Its Relationship with Vocational Interests

Dr. Shankarlinge Gowda[1], Dr. Chandrakant Jamadar[2]*

ABSTRACT

The present study aims to find out the prevalence of shyness among adolescents in tribal and rural areas as well as to find out the relationship between of occupational preference among adolescents of tribal and rural areas, influence of shyness levels, gender, and income on job preference among the adolescents. The experience of shyness can occur at any or all of the following levels: cognitive, affective, physiological and behavioural and may be triggered by a wide variety of situational cues. Since shyness could affect any dimension, the present study aims to identify the influence of shyness on occupational preference of the adolescents. The study of adolescent shyness has implications for understanding some of the more extreme examples of adolescent violence as exhibited by recent high school shootings perpetrated by shy, socially isolated, angry adolescents labeled as "cynically shy" (Carducci, 2000) and the development of strategies for reducing the social isolation experienced by such socially disenfranchised adolescents. Finally, severe shyness that continues into the later years of life can result in chronic social isolation that leads to increasingly severe loneliness and related psychopathology, and even to chronic illness and a shorter life span. Lastly, after studying the shyness aspects and relationship with other variables, an attempt will be made to suggest few remedial measures for shyness.

Keywords: *Shyness, Cognitive, Affective, Tribes And Behavior*

Shyness may be defined experientially as excessive self-focus characterized by negative self-evaluation that creates discomfort and/or inhibition in social situations and interferes with pursuing one's interpersonal or professional goals. The experience of shyness can occur at any or all of the following levels: cognitive, affective, physiological and behavioural and may be triggered by a wide variety of situational cues. Among the most typical situations are interactions with authorities and strangers, one on one opposite sex interactions, and unstructured social settings. Subcategories of shyness reflect the degree (i.e., mild social awkwardness to totally inhibiting social phobia) and frequency of experienced shyness and include chronic shyness

[1] Asst. Professor, Maharaja College, University of Mysore
[2] Asst. Professor, Postgraduate Department of Studies in Psychology, Maharani Arts College, J.L.B. Road, Mysore, Karnataka
*Responding Author

(self-labeling as shy and the experience of shyness in numerous social situations), situational shyness (the experience of shyness in specific social situations), and shy extroverts (experience anxiety and negative self-evaluation but are publicly outgoing). Although similar in its overt expression, introversion is not a subcategory of shyness. Shy individuals would prefer to be with others but are restrained by the experience of shyness. (Brophy, 1996). Bell *et al* (1994) suggest that certain young adults high in shyness (especially those also high in defensiveness) may be among the subset of the population at increased risk for Parkinson's disease later in life. Jasnoski, Bell, and Peterson (1994) reported that there is a structural connection between childhood shyness and adult panic attacks. Three paths were confirmed, the first path with hay fever, the second with anxiety, and the third with a combination of anxiety and anxiety sensitivity.

Shyness is a big obstacle in the social capabilities of a person. It hinders him or her from realizing the potentials that can only be done in the social context. People who are experiencing shyness is on the increase too, an estimated 10 per cent over the last decade. Shyness and its impact on behaviour have been subjects of interest to many researches. The following section presents a review of various studies done in the area of shyness.

Shy people may be quiet, but there's a lot going on in their heads. When they encounter a frightening or unfamiliar situation--meeting someone new, for example--a brain region responsible for negative emotions goes into overdrive. But new research indicates that shy people may be more sensitive to all sorts of stimuli, not just frightening ones. The findings come courtesy of brain scans of 13 extremely shy adolescents and 19 outgoing ones. Researchers, led by Amanda Guyer, a development psychologist at the National Institutes of Health in Bethesda, Maryland, placed each child in a functional magnetic resonance imaging machine and had them play games in which they could win or lose money. The study subjects--who were classified as either shy or outgoing based on psychological testing--were instructed to press a button as quickly as possible after being shown a signal. If they pressed the button in time, they won money, or at least prevented themselves from losing it. Both groups performed similarly, and there was no difference in the activity of their amygdalas--the brain region that governs fear. Shy children, however, showed two to three times more activity in their striatum, which is associated with reward, than outgoing children, the team reports in the 14 June issue of the *Journal of Neuroscience*. "Up until now, people thought that [shyness] was mostly related to avoidance of social situations," says co-author and child psychiatrist Monique Ernst. "Here we showed that shy children have increased activity in the reward system of the brain as well."Why this would be the case is still not clear. "One interpretation is that extremely shy children have an increased sensitivity to many types of stimuli--both frightening and rewarding," says Guyer. There are other possibilities as well, says Mauricio Delgado, a psychologist at Rutgers University in Newark, New Jersey. For example, increased activity in the striatum may help shy children cope with the anxiety of stressful situations, although not enough so to help them overcome their shyness. These findings are also significant because they may help researchers understand why shy children develop psychiatric problems at an increased rate later in life, says Brian Knutson, a

psychologist at Stanford University in Palo Alto, California. Because shy children appear to be more sensitive to winning and losing, they may experience emotions more strongly than others, putting them at risk for emotional disorders such as anxiety and depression. On the flip side, shy children may experience positive emotions such as success very strongly, helping them succeed, Knutson says. (By Michael Hochman, Science NOW Daily New, (2006)

Research (Monique Laberge et. al, 2006) shows 25 percent of the time genetic predisposition to shyness does not develop into shyness. Some researchers believe that a shy temperament may require environmental triggers, such as insecurity of attachment in the form of difficult relationships with parents, family conflict or chaos, frequent criticism, a dominating older sibling, or a stressful school environment. Research has also identified a strong cultural link to shyness. In the United States, shyness surveys typically show that shyness is highest among Asian Americans and lowest among Jewish Americans. Using culturally sensitive adaptations of the Stanford Shyness Inventory, researchers in eight countries administered the inventory to groups of 18 to 21 year olds. Results showed that a large proportion of participants in all cultures reported experiencing shyness to a considerable degree—from 31 percent in Israel to 57 percent in Japan and 55 percent in Taiwan. In Mexico, Germany, India, and Canada, shyness levels were close to the U.S figure of 40 percent. In all countries, shyness is perceived as more negative than positive, with 60 percent or more considering shyness to be a problem. There is no gender difference in reported shyness, but males tend to conceal their shyness because it is considered a feminine trait in most countries. For example, in Mexico, males report shyness less often than females do.

How you react to stress influences how easily you resist or succumb to disease, including viruses like HIV, discovered UCLA AIDS Institute scientists. Reported in the Dec.15 edition of Biological Psychiatry, (Elaine Schmidt, 2003) the new findings identify the immune mechanism that makes shy people more susceptible to infection than outgoing people.

The study (Carducci, 2000) was conducted to examine gender differences in the self-selected strategies used by shy individuals to deal with their shyness. The pattern of results indicates that shy females are more likely than shy males to deal with their shyness by selecting strategies that involve turning to others while shy males are more likely than shy females to select strategies that involve taking actions by themselves. Such a pattern of results is consistent with the more general “tend-and-befriend” response to stress in females characterized by seeking and providing social support. Because social norms favor males as the initiator of social contact, shy males may be more inclined to select strategies that are more proactive, public, and done without social support. Such strategies are also more likely to carry a greater risk of rejection and public embarrassment for shy males should their individualistic efforts to initiate social contact fail.

Shyness and academic achievement

The research literature (2007) supports an interactions interpretation of the origins of shyness: strong genetic predispositions in some newborns and strong experiential factors operating with

some adolescents and adults to create shyness. Being born timid, easily aroused, and not responsive to social engagement overtures leads to less frequent social interactions with parents, siblings, family and friends... promoting a shy response style. Although many children who are shy overcome it in time, many others remain shy all of their lives. However, research also shows that some people have become shy in adulthood who were not so previously, usually due to experiences of rejection, conditions that lower self esteem, and fears of failure in social domains. Social anxiety is an experience of fear, apprehension or worry regarding social situations and being evaluated by others. People vary in how often they experience anxiety in this way or in which kinds of situations. Anxiety about public speaking, performance, or interviews is common. Social anxiety can be related to shyness. The experience is commonly described as having physiological components (e.g. sweating, blushing), cognitive/perceptual components (e.g. belief that one may be judged negatively; looking for signs of disapproval) and behavioral components (e.g. avoiding a situation). It can also be associated with Asperger's Syndrome. Social anxiety causes difficulty with social interaction.

As far the prevalence of shyness on tribal population, the researcher did not get literature back up as expected. Even a thorough search in the Internet, CD-ROM, books and Journals did not yield any results. The present study aims to find out the prevalence of shyness among adolescents in tribal and rural areas as well as to find out the relationship between of occupational preference among adolescents of tribal and rural areas, influence of shyness levels, gender, and income on job preference among the adolescents. The experience of shyness can occur at any or all of the following levels: cognitive, affective, physiological and behavioural and may be triggered by a wide variety of situational cues. Since shyness could affect any dimension, the present study aims to identify the influence of shyness on occupational preference of the adolescents. The study of adolescent shyness has implications for understanding some of the more extreme examples of adolescent violence as exhibited by recent high school shootings perpetrated by shy, socially isolated, angry adolescents labeled as “cynically shy” (Carducci, 2000) and the development of strategies for reducing the social isolation experienced by such socially disenfranchised adolescents. Finally, severe shyness that continues into the later years of life can result in chronic social isolation that leads to increasingly severe loneliness and related psychopathology, and even to chronic illness and a shorter life span. Lastly, after studying the shyness aspects and relationship with other variables, an attempt will be made to suggest few remedial measures for shyness.

Shyness is something that all people experience at one time or another. In most cases it is a normal, temporary behavior. In children, some shyness is normal, especially when they are around 5-6 months of age, and then again at about two years of age. Shyness at these ages is considered a normal part of development. Shyness becomes a problem in a child when it interferes with relationships with other people, with social situations, school, and/or other important aspects of a child's life. Problems with shyness are usually evident by the time a child reaches three years of age.

The Soliga Tribe lives in the tropical evergreen forests of South India. Soliga means 'people of the bamboo', a name based on their belief that their ancestors originated from the bamboo. It also reflects the Soliga's close association with nature, referring to the dense thickets they inhabit. Soligas believe that human life is intertwined with the eco-system. Their love for nature is reflected in their local tribal laws. Fruits and berries are harvested only from trees which flower in abundance and very ripe or raw fruits are not collected. This leaves enough fruits for birds and other animals that also depend on them. Soligas are the major indigenous tribes of BR Hills situated in Chamarajanagar district of Karnataka state in south India.Since time immemorial, Soligas have led a semi-nomadic life and were engaged in shifting cultivation. Collection of non-timber forest products (NTFPs) like honey, lichens, soap nut, roots of Magali (Decalapis hamiltonii), fruits of Amla (Emblica officinalis), Chilla (Strychnous patatorum) and Alale (Terminalia chebula), is another important, but relatively recent occupation (Ramesh, 1989). Nearly 50% of the Soligas (meaning those who originated from Bamboo) income is from sustainable harvesting of minor forest produce. They live in podus or settlements of 10 to 50 thatched huts.

Even the Soliga practice of cultivation is environment friendly. A piece of agricultural land is not cultivated beyond 5 to 7 years. After this period, land is left untouched for 50 to 75 years, so that the forest takes root once again. Their dependence on the forest for survival ensures a harmonious existence with nature. It is a symbiotic relationship where the people are connected to the land in an intricate web of life.

OBJECTIVES

1. To assess the influence of gender, age, class, birth order and income on shyness-cognitive/affective, physiological, action oriented domains and total shyness scores of tribal and rural adolescents
2. To assess the vocational interests of tribal and rural students
3. To study the influence of secondary variables on vocational interests
4. To suggest proper remedial measures reduce shyness

Hypotheses

Following directional hypotheses have been formulated for the present study.

H1: Adolescents from tribal and rural areas differ significantly in their vocational interests

H2. There will be significant association between shyness levels and vocational interests.

H3. There will be significant association between gender and vocational interests.

H4: There will be significant association between income and vocational interests.

Sample

In the present investigation, 382 children randomly selected for the present investigation. Predominantly one school from tribal belt where the education is meant exclusively for tribal

children in B R Hills was selected. The tribes living basically are 'soliga's. Another two schools from rural areas were selected to compare the shyness and vocational interest.

Variables selected

Independent variables	**Dependent variables**
1. Shyness levels (Low, medium and High)	1. Shyness scores (Cognitive/affective domain, physiological and action oriented)
2. Area (Tribal and Rural)	2. Vocational interest (measured in 8 different areas-
3.Gender (Male and female)	
4. Age groups (below 14 years and above 14 years)	
5. Birth order (1, 2 or 3 and above)	
6. Class (8, 9 and 10)	

Tools used: Shyness Assessment Test (D'Souza, 2006).

Procedure

The tests were administered to the subjects in groups of 4-6 subjects per group. Data collection was done in two sessions and each session lasted for about 30-45 minutes. First, the researcher, established rapport with the subjects and they were asked to introduce themselves. The purpose of the study was made clear to them. Then they were administered the Shyness questionnaire. They were given appropriate instructions and the questions were read out to them. They were asked to indicate their responses in the respective sheets given to them. Whenever they had doubt in understanding questions, the test administrator made those questions very clear to them in their local language.

In the second session interest record was administered after a gap of 3-4 days. They were given appropriate instructions and the questions were read out to them. They were asked to indicate their responses in the respective sheets given to them. Whenever they had doubt in understanding questions, the test administrator made those questions very clear to them in their local language.

The data collected were examined for incompleteness, wrong entries and other issues. Such respondent sheets were discarded. The remaining data sheets will be coded, a master chart was prepared, this chart was entered into the computer, using statistical software package, the data was analyzed using various statistical tests.

Statistical Techniques:

Following statistical methods were employed in the present study using SPSS for Windows (SPSS, 2006). Descriptive Statistics , Cross tabulation (Contingency coefficient test)Independent samples 't' test, ANOVA-Two-way, Chi-square test

RESULT AND DISCUSSION

Groups and vocational interests

Table No.1 Frequency and percent values for vocational preference on high interests by adolescents of tribal and rural areas and results of chi-square tests.

Sl. No	Factor	Groups		
		Tribal	Rural	Total
1	Mechanical	1 (0.5%)	12 (6.0%)	13
2	Business	0 (0.0%)	23 (11.5%)	23
3	Scientific	0 (0%)	2 (1.0%)	2
4	Aesthetic	2 (1.4%)	12 (6.0%)	14
5	Social	27 (14.83%)	26 (13.0%)	53
6	Clerical	52 (28.6%)	29 (14.5%)	81
7	Outdoor	100 (54.9%)	96 (48.0%)	196
	Total	182 (100.0%)	200 (100.0%)	382

Chi-square =64.89; P=.000

Chi-square test revealed a significant association between groups and vocational interests, as we find that the obtained chi-square value of 64.89 was found to be significant at .000 level. From the frequencies and percentages it is clear that adolescent tribals least preferred mechanical, business, scientific and aesthetic jobs. Their preference was maximum for outdoor jobs, followed by clerical and social. Further, when compared with tribals, 48.0% of the rural adolescents preferred outdoor, 14.5% of them preferred clerical, 13.0% of them indicated social, 11% of them inclined to business and so on. We see a clear cut differentiation in the job preference by adolescents of rural and tribal areas. The job interests of rural adolescents were much varied than tribal adolescents (Figure 4.4).

Shyness levels and vocational interests

Table.2 Frequency and percent values for vocational preference on high interests by adolescents of with different levels of shyness and results of chi-square tests.

Sl. No	Factor	Shyness levels			
		Low	Medium	High	Total
1	Mechanical	3	5	5	13
2	Business	15	6	2	23
3	Scientific	0	0	2	2
4	Aesthetic	0	4	10	14
5	Social	32	20	1	53
6	Clerical	10	61	10	81
7	Outdoor	5	189	2	196
	Total	65	285	32	382

Chi-square =272.60; P=.000

When shyness levels were verified against vocational interests, chi-square test revealed a significant association between shyness levels and vocational interests, as we find that the obtained chi-square value of 272.60 was found to be significant at .000 level. From the frequencies and percentages it is clear that adolescents with lower levels of shyness preferred more of social and business jobs, adolescents with medium levels of shyness preferred outdoor, mechanical and clerical jobs. Adolescents with higher levels of shyness preferred more of scientific, aesthetic and mechanical jobs and least of business and social jobs. We see a clear cut differentiation in the job preference by adolescents with different levels of shyness.

Gender and vocational interests

Table.3. Frequency and percent values for vocational preference on high interests by male and female adolescents and results of chi-square tests.

Sl. No	Factor	Gender		
		Male	Female	Total
1	Mechanical	10	3	13
2	Business	18	5	23
3	Scientific	2	0	2
4	Aesthetic	4	10	14
5	Social	41	12	53
6	Clerical	61	20	81
7	Outdoor	80	116	196
	Total	216	166	382

Chi-square =53.29; P=.000

Chi-square test revealed a significant association between gender and vocational interests, as we find that the obtained chi-square value of 53.29 was found to be significant at .000 level. From the frequencies and percentages it is clear that male adolescents preferred more of mechanical, business, scientific, social, and clerical jobs, where as female adolescents preferred more of outdoor and aesthetic jobs. We see a clear cut differentiation in the job preference by male and female adolescents. The job interests of male adolescents were much varied than female adolescents.

Income and vocational interests

Table.4. Frequency and percent values for vocational preference on high interests by adolescents with different income background and results of chi-square tests.

Sl. No	Factor	Income (in Rs.)		
		Below 5000	Above 5000	Total
1	Mechanical	7	6	13
2	Business	11	12	23
3	Scientific	0	2	2
4	Aesthetic	8	6	14
5	Social	40	13	53
6	Clerical	40	41	81
7	Outdoor	158	38	196
	Total	264	118	382

Chi-square =39.631; P=.000

When income levels were verified against vocational interests, chi-square test revealed a significant association between income levels and vocational interests, as we find that the obtained chi-square value of 39.361 was found to be significant at .000 level. From the frequencies and percentages it is clear that adolescents with lower levels of income preferred more of social and outdoor jobs, adolescents with income levels of above Rs. 5000 preferred scientific and business jobs. We see a clear cut differentiation in the job preference by adolescents with different levels of income (Figure 4.7).

SUMMARY AND CONCLUSION

Main findings of the present study are

- ✓ Tribal adolescent least preferred mechanical, business, scientific and aesthetic jobs. Their preference was maximum for outdoor jobs, followed by clerical and social.
- ✓ Adolescents with lower levels of shyness preferred more of social and business jobs, adolescents with medium levels of shyness preferred outdoor, mechanical and clerical jobs. Adolescents with higher levels of shyness preferred more of scientific, aesthetic and mechanical jobs and least of business and social jobs

- ✓ Male adolescents preferred more of mechanical, business, scientific, social, and clerical jobs, where as female adolescents preferred more of outdoor and aesthetic jobs.
- ✓ Adolescents with lower levels of income preferred more of social and outdoor jobs, adolescents with income levels of above Rs. 5000 preferred scientific and business jobs

LIMITATIONS OF THE STUDY

- Sample size was limited
- Test was self-appraisal test
- Sample selected from only from adolescent age groups
- Only few variables were subjected to investigation
- No intervention part for treatment of shyness was considered.

Recommendations for Further Research

- Further research should be focused on the other age groups such as children and adults exclusively on tribal population
- Further research also needs to be conducted on different tribes from different states.
- Research should focus on impact of displacement of tribal's to the fringes could also be studied.
- Many studies have been done on impact of displacement from forest to the fringes. No in depth psychological research has been recorded. Future researchers can look into these aspects especially perceptual process and so on.

SUGGESTIONS

- ➢ It is highly suggested that tribal children and adolescents should be given job orientation courses so that they can think diversely than traditional jobs.
- ➢ It is highly suggested that tribal children and adolescents should be given skill development courses to equip themselves with rural and urban counterparts.
- ➢ It is highly recommended that tribal children and adolescents should be given maximum exposure through media and other sources regarding job placements and enough opportunities should be provided to them

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Quality of Life among Widows

Dr. Chandrakant Jamadar[1]*, Dr. S. P. Melkeri[2], Dr. Ashok Holkar[3]

ABSTRACT

This paper gives an overview of the current status of widows quality of life for assessment of widows quality of life scale used reliable and validated scale by B.L. Dubey, Padma Dwivedi, S.K. Verma Social Scientist, post Graduate medical Institute, Chandigarh ,India. Test was administered to a random sample 200 in different age, domicile and, literacy group widows from Mysore. For analysis used relevant statistical tool like mean, standard deviation t-test. The findings of the study reflects that , the working widows have better quality of life than the others, and another important findings that those are literate they also have better quality of life than the illiterate widows.

Keywords: *Widows, Quality Of Life, Occupation And Society.*

A widow is a woman whose husband has died, while a widower is a man in that situation. The state of having lost one's spouse to death is termed widowhood. These terms are not applied to a person after he or she becomes divorced from their former spouse, though they may sometimes be used after the former spouse has died.

This term "widowhood" can be used for either sex, at least according to some dictionaries, but the word widower hood is also listed in some dictionaries. Occasionally, the word viduity is used. The adjective form for either sex is widowed.

The treatment of widows around the world varies, but unequal benefits and treatment generally received by widows compared to those received by widowers globally has spurred an interest in the issue by human right activist. In societies where the husband is the sole provider, his death can leave his family destitute. The tendency for women generally to outlive men can compound this, since men in many societies marry women younger than themselves. In some patriarchal societies, widows may maintain economic independence. A woman would carry on her spouse's business and be accorded certain rights, such as entering guilds. More recently, widows of political figures have been among the first women elected to high office in many countries, such as Smt. Shanta Patil from Gulbarga, Karnataka.

[1] Asst. Professor, Post Graduate Department of Studies in Psychology, Maharani's College for Women, Mysore.
[2] Professor and Chairman, Department of Psychology, Gulbarga University Gulbarga ,Karnataka.
[3] Asst. Professor, Government Arts First Grade College, Bangalore, Karnataka
*Responding Author

Widows in India have a pronoun problem. The estimated 40 million women widows in the country go from being called "she" to "it" when they lose their husbands. They become "de-sexed" creatures.

Clearly, it's more than a problem of language, although that discrimination goes further, with epithets such as "husband eater" used against them. In the northern Indian state of Punjab, a widow is referred to as randi, which means "prostitute" in Punjabi. In this region, they usually arrange for the widow to marry her deceased husband's brother because being owned by a man is a way to avoid being raped.

"Widowhood is a state of social death, even among the higher castes," says Mohini Giri, a veteran activist in the fight for women's rights who was nominated for the Nobel Peace Prize in 2005. She is also the director of the Chennai-based social work nonprofit organization Guild for Service. "Widows are still accused of being responsible for their husband's death, and they are expected to have a spiritual life with many restrictions which affects them both physically and psychologically." A widow prays in an ashram in Vrindavan. Women are often forced into prostitution by corrupt heads of such ashrams. (Sara Barerra)

Although widows today are not forced to die in ritual *sati* (burning themselves on their husband's funeral pyre), they are still generally expected to mourn until the end of their lives. the Hindu progenitor of mankind: "A virtuous wife is one who after the death of her husband constantly remains chaste and reaches heaven though she has no son."

Whether young or old, widowed women leave behind their colourful saris, part with their jewelry, and even shave their heads, if they are in the more conservative Hindu traditions. All of this is designed so as not to encourage male sexual desire, according to Meera Khanna, a trustee of the New Delhi-based Women's Initiative for Peace in South Asia, and a contributor to of a book called Living death : Trauma widowhood in India.

"The widow is 'uglified' to deprive her of the core of her femininity," writes Khanna. "It is an act symbolic of castration. She is deprived of the red dot between her eyebrows that proclaims her sexual energy."

Widows seem to follow rules based on tradition because they have internalized them. They keep doing what other widows did without asking, resigned to a kind of fate—such as placing restrictions on their own diets. Orthodox Hindus believe that onions, garlic, pickles, potatoes, and fish fuel sexual passions by stimulating the blood, but these are the same foods necessary to avoid malnutrition or even death. For India as a whole, mortality rates are 85 percent higher among widows than among married women, according to research by the Guild for Service.
In much of Indian society—across caste and religion—a widow is often perceived by family members to be a burden and sexually threatening toward marriages.

A widow is a woman whose spouse has died, while a widower is a man in that situation. The state of having lost one's spouse to death is termed widowhood. These terms are generally not applied to a person after he or she becomes divorced from their former spouse. Widow This term "widowhood" can be used for either sex, at least according to some dictionaries, but the word widower hood is also listed in some dictionaries. Occasionally, the word avidity is used. The adjective form for either sex is widowed.

The treatment of widows around the world varies, but unequal benefits and treatment generally received by widows compared to those received by widowers globally has spurred an interest in the issue by human rights activists

Every country has widows. As India has a population as well as 100 nations, it is 100 times more than other countries. In addition to poverty, the unavailability of medicine, the increase in alcoholism, terrorism and natural calamities like Tsunami's, have caused many deaths. When we see the number of widows in India it is unbelievable.

In India, people don't like a widow to cross the path in front of them when they are beginning a journey on foot, bicycle or car. It is considered bad luck and a sign of future failure. Unfortunately, most Indian cultures consider widows as a sign of misfortune and bad luck.
. "When [a woman] loses her husband and becomes a widow, she loses her identity. A woman deprived, abandoned, malnourished will naturally have a high mortality rate."

For the more than 40 million widows in India – 10% of the country's female population – life is what some have described as "living sati", a reference to the now the prohibited practice of widow burning. Some are as young as 10 years old and are forced to spend the rest of their days in seclusion or earning a living through prostitution.

Only 28% of the widows in India are eligible for pensions, and of those, less than 11% actually receive their entitled payments. If a woman is not financially independent, she is at the mercy of her in-laws and her parents. And if they do not have the will or resources to take care of her and her children, she will be treated like an "untouchable". Financial aid is crucial to widows wanting to lead a self-sufficient life, but the government has failed to provide it.

Many of the 16,000 widows in Vrindavan have no choice but to beg in the streets. Traditionally, widows are only allowed one meal a day and renounce all earthly pleasures. However, Giri provides an alternative refuge and "ashram" for destitute widows in the state of West Bengal. "We break away from the traditional norms of widows being given one meal a day and not being allowed to have meat or certain foods such as garlic and onions."

Orthodox Hindus believe that both meat and certain vegetables have pulses that stimulate blood and are therefore impure. It is no wonder that deaths as a result of malnutrition are 85% higher

among widows than married women, according to the Global Ministries Foundation. They are even expected to fast several times a month, sometimes eating nothing but fruit for days on end. In the last 20 years, Giri has come to believe that "traditions are manmade and are prevalent in society due to its widespread acceptance in the social milieu … a patriarchal Brahaminical society has enforced wrong values in society towards widows". Nevertheless, trying to change the taboos surrounding remarriage and widows' conduct is only possible if the government enforces education to explain their harmful effects. The states of Andhra Pradesh and West Bengal have the highest percentage of widows in India, primarily because of objections to remarriage with a recent report conducted by the national commission of women stating that 74% of destitute widows live in West Bengal; there is a clear indication that implementing legislation has been unsuccessful. "Widowhood is not a priority within the government. It is only now that we are pushing the issue with the government, the planning commission and also at the United Nations." However, the recent 33% quota for women at grassroots political level is a source of great strength for the advocacy of women's rights and enough to see a perceptible change. Giri has established many pioneering shelters for widows that aim to enhance their skills and make them more economically independent. But to make a difference in the longer term, traditional values will have to change.

A widow must wear only white series and fully cover her face. The widows must also stay aloof and alone from the ordinary family, and should not show their face to the ordinary public. There are also families who blame the widow for the death of her husband, saying that her bad luck has killed the husband and made the children orphans. For instance, if a husband has AIDS and dies, he leaves the widow and her family victims of that disease, by no mistake of their own, but she is blame WIDOWS in India face multiple, often conflicting, and social expectations. Their status is defined by a complex and diverse host of religion-based personal codes, regional, jati, kinde based customs, and government laws. The condition of widows in different groups, cultural areas and classes are therefore vastly different. A new anthology, Widows in India: Social Neglect and Public Action, assembles papers produced for a conference on this topic held in 1994 in Bangalore.

Quality of life

"The problem of widows—and especially of child widows—was largely a prerogative of the higher Hindu castes among whom child marriage was practiced and remarriage prohibited. Irrevocably, eternally married as a mere child, the death of the husband she had perhaps never known left the wife a widow, an inauspicious being whose sins in a previous life had deprived her of her husband, and her parents-in-law of their son, in this one. Doomed to a life of prayer, fasting, and drudgery, unwelcomes at the celebrations and auspicious occasions that are so much a part of Hindu family and community life, her lot was scarcely to be envied.

On the other hand, the lower, particularly Sudra, castes and the (so-called) 'Un-touchable'—who represented approximately 80 per cent of the Hindu population—neither practiced child marriage nor prohibited the remarriage of widows."

Old age is the period of decline and closing period of life. According to Elizabeth Hurlock 1981) Old age has been classified as early old age and advanced old age [70-end of life].According to Sowmiya (2012) Ageing is a normal, inevitable, biological and universal reality. According to WHO (1996)"Quality of life is defined a individual's perceptions of their position in the context of the value system in which they live and in relation to their goals, expectation, standards and concerns". Quality of life is very imperative for elderly who are widowed, divorced and separated to enhance their wellbeing. Inclusion and rehabilitation are major concern which should be rendered to promote the standard of life of WDS. It is operational zed in this study that neglected institutional women are Widows, divorced and separated. Widows, divorced and separated are unacknowledged, invisible, not main stream individuals. separated widows state is magnified as negative life event which is traumatic making them to go in the paths of remorse and aloofness which is dehumanising. There are vivid reasons to be victims of widowhood, divorced and separated whereby they are neglected due to deviant myths and misconceptions concerning WDS. The widowhood in elderly is a state of elderly women who has lost her husband by death and has not married again It may be granted if the spouse is mentally incompetent. Separated is couple intentionally or on-intentionally bonded in marriage not living together? The common problems of WDS are economic hardship, higher rates of common mental health problems, adjustment problems, loneliness, phobias to live alone, social stigma, socialisolation and neglect, low self-esteem, widows remarriage is highly discourage in high class, poor nutrition, compelled for prostitution, draining in poverty, indulging in begging, inadequate shelter, domestic violence among families members. Prone to rape, poor accessibility of health care, migration, neglected by members of justice providers , According to the Times of to India (2012) highlights that Tamilnadu has highest percentage [8.8%] of widows, divorced and separated. The percentage of WDS females was almost three times than of men [29%against 10%]. Mohammed Tagh Sheykshin [2006] found that widowhood leads them to bereavement, readjustment, low social status entitled as vulnerable section of society. Giles [2013] says on impact of divorce women that it leads to financial and emotion distress which curbs the quality of life. So it is obligatory to cater to the rehabilitation needs of WDS who has enormous negative implications.

METHODOLOGY

Statement of the problem: To study on quality of life among widows.

Objectives of the study:

- To study the quality of life among widows.
- To understand the rural and urban widows in their quality of life.
- To assess the literate and illiterate widows quality of life.
- To understand the quality of life of widows is their different age group.

Hypothesis

- There is a significant difference in quality of life among widows.
- There is significant differences between rural and urban widows are their quality of life.
- There is a significant difference between literate and illiterate is their quality of life among widows.
- There is a significant differences in different age group widows his their quality of life.
- There is a significant difference between working and nonworking widows is their quality of life.

Variable

Dependent variable: quality of life

Independent variable: widows

Sample size: A sample of 200 widows will be taken for the study.

Widows	**200 sample**
Literate	25
Illiterate	25
Rural	25
Urban	25
Age group 20-40	25
41 and above	25
Working widows	25
Nonworking widows	25
Total	200

The sample consist of 200 frames Literate, illiterate rural and urban and different age group of widows from Mysore district. The sample collected sand method.

Design: Quasi experimental designs.

I'm going to do a psychological experiment where I make people different ages and then see how they react to loud noises. Well, I'd like to. Unfortunately, even with our advanced quantum physics and computers, we cannot reverse or control age like that. Psychological researchers are forced to work around the issue.

Because we can't reverse someone's age, we have to work with people who are already that age. But we miss some things in the process. But I'm getting ahead of myself.

A **true experiment** has one main component - randomly assigned groups. This translates to every participant having an equal chance of being in the experimental group where they are subject to a manipulation or the control group where they are not manipulated.

A **quasi-experiment** is simply defined as not a true experiment. Since the main component of a true experiment is randomly assigned groups, this means a quasi-experiment does not have randomly assigned groups. Why are randomly assigned groups so important since they are the only difference between quasi-experimental and true experimental?

When performing an experiment, a researcher is attempting to demonstrate that variable A influences or causes variable B to do something. They want to demonstrate cause and effect. Random assignment helps ensure that there is no pre-existing condition that will influence the variables and mess up the results.

A silly example would be something like 'Does chemical X1 cause blindness?' If you accidentally put all of the people wearing glasses in the condition where you spray X1 in someone's face, then your results are going to be skewed. This is an extreme and overly simplistic example, but it is demonstrating why normally an experimenter wants to randomly assign people into different groups. Let's look at some more realistic and typical quasi-experiments in psychology.

Materials *:* Quality of life scale-R(QLS-R)B.L. Dubey, Padma Dwivedi, S.K. Verma Social Scientist, post Graduate medical Institute, Chandigarh ,India. One of the relatively newer concepts in the field of organizational behavior is the quality of life. It has not received due care and attention so far, has it deservers. There is a board agreement, however that quality of life, general satisfaction level including job satisfactions and health, particularly mental health, are all important and inter-related concepts and need to be studied. They are all, directly or indirectly, related to the healthy growth of industry in a country and it is output in the long run. Although, all these are inter-related, they are not identical; rather they may be complimentary to each other. While some work as been done in the other areas, quality of life had been a neglected area it is now receiving some attention and is likely to be given it is proper place in times to come. It is particularly related to the aspects of positive mental health, which is more than the mere absence of ill-health and needs to be studied in it is own right.

Initial pool of items: This scale consists of 20 items. Reviewing th related literature, Maslow hierarchy of needs and factors of quality of life as suggested by verma (1986), a large number of items were selected/ constructed. The preliminary form of the scale consisted of 20 items. This preliminary form of the quality of life scale was given to industrial psychologists, sociologist and business executives for there opinion/modifications/ corrections, if any, required. After suitable modification, the first form of quality of life scale consisted 29 items with Likert (1932) types scoring systems consisting of 5 categories of agreement- disagreement.

Scoring: As mentioned earlier, the Liket type scoring systems consisting 5 categories of agreement- disagreement was applied to each item of final form of quality of life scale. The scoring weights for each item ranges from 1to5 (strongly disagree to strongly agree 1 to5); with

the range of possible total scores from 24-120. Higher score indicates better quality of life (Items 2, 5, 23 are scored in reverse direction); with the average score 72 and more, as better quality of life score,

Statistical analysis*:* Statistical techniques used for analysis. the researcher after collecting the data, the data were edited and coded. The data were then analyzed using various statistical tools like, mean SD and t-test.

ANALYSIS OF RESULTS

Table No.1.Mean,SD and t-value of quality of life of widows in literate and illiterate.

Group	**Literate**	**Illiterate**
Mean	70.32	54.68
SD	5.18	7.54
N	25	25
t-value	8.5474	
p-value	0.0001	

The above table shows that the Mean, SD, and t- value of widows in their quality of life, Literate and illiterate. Literate widows Mean and SD is 70.32 and 5.18 is higher than the illiterate widows is 54.68 and 7.54 respectively. The literate widow's score indicates that, they have better quality of life of than the illiterate widows. The calculate t- value is 8.54.it is significant 0.0001 level. Therefore, the formulated hypothesis is that, "there is significant differences between literate and illiterate widows in these" quality of life. Hence the formulated hypothesis is accepted. Related to this research many results have found. But" major research mentioned here. According to "Archana Patkar (she conducted research on) Socio-economic status and female literacy in India. It seems as if the universally acclaimed need for literacy has recently re-gained currency in India, justifying enormous investment in areas traditionally scorned for their low rate of return. The focus on increased enrolment, retention and achievement in primary education, in conjunction with feverish Total Literacy Campaigns conducted by the Government of India (GOI), may be credited with steering the spotlight away from more pressing structural problems such as the deeply ingrained gender bias at all levels of the education-employment matrix and the inherently gendered nature of the ideological framework underlying educational provision in India.

Seldom questioned is the value and relevance of the *kind* of literacy being advocated or the logic behind the slogan 'basic education as a basic human need'. It can be argued that churning out batches of literate women does not guarantee the articulation of their needs or their participation in planning and decision making. This paper argues that, divorced from other areas such as women's low socio-economic status, labour market inequalities and legal bias, literacy

programmes are a relatively inexpensive and politically expedient palliative in their present limited form.

Table No.2.Mean, SD and t-value of quality of life of widows in Rural and Urban.

Group	**Rural**	**Urban**
Mean	54.60	65.04
SD	6.29	6.37
N	25	25
t-value	5.8316	
p-value	0.0001	

The above table shows that, the Mean, SD, and t- value of widows in their quality of life, Rural and Urban. Rural widows Mean and SD is 54.60 and 6.29 is higher than the Urban widows is 65.05 and 7.6.37 respectively. The rural widows score indicates that, they have better quality of life of than the urban widows. The calculate t- value is 5.8316.it is significant 0.0001 level. Therefore, the formulated hypothesis is that, "there is significant differences between Rural and Urban widows in these" quality of life Hence the formulated hypothesis is accepted. Related to this research many results have found "but major research mentioned here. According to "KAREN L HORNUNG" Loneliness among older Urban Widows "The purpose of this study was to determine the extent of loneliness among older urban widows in relation to seventeen social and demographic variables. The variables examined were: age, length of marriage, length of widowhood, education, household companion, frequency of telephoning, organizational activity, sufficiency of contact with a confidant, satisfaction with visiting patterns of relatives and friends, confinement, self-rated health, occupation, income, transportation, satisfaction with housing, feelings about the past year, and time spent alone.^ The data were obtained by use of the Loneliness Questionnaire for Older Widows (LQ-OW) from a random sample of 80 older urban widows in Lincoln, Nebraska. The LQ-OW was adapted from the "Loneliness Questionnaire" (Woodward, 1967). The LQ-OW contained specific items related to the variables, questions on loneliness, and the Loneliness Inventory. The inventory included seventy-seven questions requiring the participant to indicate under what circumstances she experienced loneliness. Responses of each interviewee to the Loneliness Inventory were analyzed to derive a loneliness score, ranging from zero to five.^ The Statistical Package for the Social Sciences (SPSS) was used to analyze the data. Mean loneliness scores and standard deviations were determined for each of the categories within each of the seventeen variables. To test for significant differences in the mean loneliness scores within the various categories of each of the variables, one-way analysis of variance was employed. If a significant difference was detected, the Scheffe test of multiple comparisons was applied to determine which groups were contributing to the significance. The level of significance chosen was p (LESSTHEQ) .05 for the one-way analysis of variance, and p (LESSTHEQ) .10 for the Scheffe test.^ Findings of the

study included: (1) The mean loneliness score of 1.03 for the widows interviewed revealed that, as a group, these women were not found to be lonely. A comparison of the mean loneliness scores of the thirteen populations studied as part of the Loneliness Research Project at the University of Nebraska - Lincoln revealed that older urban widows reported more loneliness than elderly (Woodward, 1971) or elderly in homes for the elderly (Wythers, 1974), but reported less loneliness than all the other groups studied. Those previously studied groups included: young adults (Seevers, 1972; Swanson, 1971), adolescents (Otto, 1973; Gladbach, 1976), housewives (Visser, 1971), divorced adults (Zabel, 1970), and low-income single parents (Bauermeister, 1978; Joern, 1977). (2) The four factors which significantly contributed to the loneliness scores of older urban widows were length of marriage, length of widowhood, satisfaction with amount of organizational activity, and feelings about the past year. The thirteen other variables were not found to be significantly related to the population studied. (3) Older urban widows who had been married fifty years or more were significantly lonelier than those married thirty to thirty-nine years. (4) Women widowed five years or less were found to be significantly lonelier than women widowed more than five years. (5) Older urban widows who had as much organizational activity as they wanted were significantly less lonely than those who did not have as much organizational activity as they desired. (6) Older urban widows who felt happy about the past year were significantly less lonely than those who felt that the past year had been either satisfactory or unhappy. (7) Older urban widows who were lonelier were those married fifty years or more, whose husband died within the last five years, who did not have the desired amount of organizational activity, and who had been unhappy the past year.

Table No.3.Mean,SD and t-value of quality of life of widows in different age group.

Group	**20-40**	**41 and above**
Mean	48.08	60.16
SD	461	6.29
N	25	25
t-value	7.7416	
p-value	0.0001	

The above table shows that, the Mean, SD, and t- value of widows in their quality of life, 20-40and 41 and above. 20-40 widows Mean and SD is 48.08 and 461 is higher than the 41 and above widows is 60.16 and 6.29 respectively. The 20-40 widows' score indicates that, they have better quality of life of widows than the 41 and above widows. The calculate t- value is 8.54.it is significant 0.0001 level. Therefore, the formulated hypothesis is that," there is significant differences between 20-40 and 41 and above widows in these" quality of life. Hence the formulated hypothesis is accepted. Related to this research many results have found but major research mentioned here. According to "Sreerupa & S. Irudaya Rajan (she conducted research on) Gender and Widowhood: Disparity in Health Status and Health Care Utilization Among the

Aged in India**.** Despite an increasing feminization of India's older population marked by a high incidence of widowhood among aged women, women's health in later life and the health consequences of widowhood has received little attention in the existing gender and gerontological scholarship in India. Based on data of a nationally representative survey by the National Sample Survey Organization (N = 34,831, ages 60 and over), this study analyzed marital status, gender, health and health care utilization, and examined the gendered nature of aging and widowhood in India. Significant differences were found in health status and utilization of health care services by gender and marital status. Widowed persons of either gender were found to be the most vulnerable and, overall, widows emerge as the most disadvantaged group.
Parkes, Murray C. MD, MRCPsych; Brown, R. J. BSc Health after Bereavement: A Controlled Study of Young Boston Widows and Widowers. Structured interviews were carried out with 49 widows and 19 widowers under the age of 45 who had been bereaved 14 months previously. A number of indices of health and emotional disturbance were shown to distinguish these bereaved respondents from a matched control group. The 13-month-bereaved group was characterized by recent disturbance of sleep, appetite and weight, by complaints of depression, restlessness, indecisiveness and sense of strain and by an increased consumption of alcohol, tobacco and tranquilizers. They were more likely than the control group to have been admitted to a hospital during the preceding year. Widowers reported an increase in acute physical symptoms although neither sex had more chronic physical symptoms than the controls. Two to four years later there was little difference in health between bereaved and control groups but there was evidence of persisting "disengagement."

Table No.4.Mean,SD and t-value of quality of life of widows in Working and non working .

Group	**Working**	**Non-working**
Mean	61.64	46.80
SD	4.61	2.53
N	25	25
t-value	14.04	
p-value	0.0001	

The above table shows that the Mean, SD, and t- value of widows in their quality of life. Working and None working widows Mean and SD is 61.64 and 4.61 is higher than the Non working 46.80and2.53 respectively. The Working score indicates that, they have better quality of life of widows then the Non working widows. The calculate t-value is 14.04 .it is significant 0.0001 level. Therefore, the formulated hypothesis is that," there is significant differences between Working and Non-working widows in these" quality of life. Hence the formulated hypothesis is accepted. Related to this research many results have found but major research mentioned here. According to "VANISRI, SHIVAKUMAR S. CHENGTI (she conducted research) Mental Health of working and nonworking widows (2015).The aim of the present study was the mental health of working and nonworking widow, The objectives of the study

were 1) to examine the significant difference in mental health between rural and urban sample, The sample consisted 120 (60 working and 60 nonworking) selected from Gulbarga district in Karnataka state. The sample is matched for the type category of widows and domicile, the sample was administered with mental health in t-test, the result revealed that there is a significant difference in mental health between working and nonworking widows.

VANISRI;MALI PATIL,K,S; CHENGTI,SHIVAKUMARS,(she conducted research) Anxiety and social support working and nonworking widows(2012).The main purpose of the present study was to study the anxiety and social support of working and nonworking widows. The objectives of the study were 1) to examine the significant difference in anxiety between working and nonworking widows 2) to examine the significant difference in social support between working and non working widows. The sample consisted of 120 (60 working and nonworking widows) selected from Gulbarga district in Karnataka state, personal data sheet , comprehensive anxiety test (Sinhas,) and P.G. ,social support questionnaire (Ritunehra .at all.) were used to collect the required data, And the date were subjected the t-test, The result revealed that there is a significant difference in anxiety social support between working and nonworking widows samples. There was more anxiety in nonworking widows the working widows have high social support than the nonworking widows.

SUMMARY AND CONCLUSION

- There is significant differences between literate and illiterate widows are their quality of life.
- The literate widow's score indicates that, they have better quality of life than the illiterate widows.
- There is significant difference between Rural and Urban widows is their quality of life.
- The Rural widow's score indicates that have better quality of life than the Urban widows.
- There is significant differences between different age group widows are their quality of life.
- The 20-40 age group widows score indicates that they have better qualities of life of widows than the 41 and above widows.
- There are significant differences between working and nonworking widows quality of life.
- The working widow's score indicates that have better quality of life than the nonworking widows.

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The Effect of Age on Uniqueness, Simplicity and Aliveness among Old Age People

Dr. Chandrakant Jamadar[1]*, Dr. Shankarlinge Gowda[2], Dr. S. P. Melkeri[3]

ABSTRACT

The present study is an attempt to investigate the conjoint of impact of age on uniqueness, simplicity and aliveness among old age people. The sample consists of 210 old age people from Mysore old age home. In 210, 105 pensioned and 105 non pensioned old age people, the data collected in random method. The result shows that, significant differences in gender, domicile and dimensions of the behavior, also age is more effective role in changing uniqueness, simplicity and aliveness.

Keywords: *Uniqueness, Simplicity, Aliveness, Peak Experience And Age*

Old age" or the "elderly" are the terms, which are frequently used, both in popular usage and in academic environment to refer to those who are above 60 years. While everyone agrees that ageing is a normal, inevitable and universal phenomenon for biologists and medical scientists, ageing refers to and is measured as deterioration in physical capabilities; psychologists measure it as a decline in various adaptive capabilities. Later adulthood is the last major segment of the life span. Sixty-five has usually been cited as the dividing line between middle age and old age (Hareven, 1976). ''Gerontologists have attempted to deal with these age-related differences among the elderly by dividing later adulthood into two groups'': the young-old, from age 65 to 74 years, and the old-old, from 75 years and above (Hall, 1980). Our society tends to define old age mainly in terms of chronological age. In primitive societies, old age is generally determined by physical and mental conditions rather than by chronological age. Such a definition is more accurate than ours.

Everyone is not in the same mental and physical condition at age 65. Ageing is an individual process that occurs at different rates in different people, and psychosocial factors may retard or accelerate the physiological changes. It is said that the statuses and roles of older persons, their culture patterns, social organization and collective behavior are affected by social change. Ageing is, no doubt, a physiological phenomenon, which is accompanied by some complex progressive changes in an organism.

[1] Asst. Professor, Post Graduate Department of Studies in Psychology, Maharani's College for Women, Mysore
[2] Asst. Professor, Maharaja College, University of Mysore
[3] Professor and Chairman, Department of Psychology, Gulbarga University Gulbarga, Karnataka
*Responding Author

Henderson (1952), "Old age is a natural and normal condition. Its pathologies are the same as those that occur at any other age period, but they are intensified by illness, family disorganization, unemployability, reduced income and dependency."

Birrren and Renner (1977), well known psychologists refer to ageing as "the sum of regular changes that occur in mature genetically representative organisms living under representative environ Davidson (1984) opines that ageing comprises of those fundamental changes not due to disease occurring in individuals after maturity which are more or less common to all members of the species and which increase the probability of death. Ageing is thus the increasing inability to resist death.

Gorman (2000) says, the ageing process is, of course, a biological reality which has its own dynamics, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role.

Uniqueness and simplicity in old age people

Discovery how a small group of committed citizens can come together to support each other in the pursuit of personal happiness and social change for the greater good. The community happiness circle is part of a long tradition of people coming together to change their own lives and create a culture concerned about the common good.

Uniqueness: Somebody singing with a striking voice, or playing with a distinctive tone or touch can convey uniqueness, as can the structure of a song (Bohemian Rhapsody, for example). A painting that clearly identifies the style of its artist or a story written about some unique period of history or place (Harry Potter) can all contribute to a work's uniqueness. An web application that does something that no other application does is also unique, even if imitated later.

Simplicity: When a song has a strong melody, a catchy tune, an unforgettable chorus or some catch phrase in the lyric, it has simplicity. A painting can achieve simplicity through economy of line or through impressionistic brush strokes, or strong composition. A limited colour or tonal range can achieve the same thing. A story can achieve simplicity through language, clear narrative, the choice of simple words, or by having a linear flow or easy to follow story line.

Aliveness: A musical performance or instrumental solo can convey a sense of aliveness just from the touch of the player and the enthusiasm that is conveyed through the musician's playing. A painting can achieve spontaneity through the deftness of the brush strokes, the freshness and immediacy of line and shape or by splashes of contrasting colour, for example. A story can achieve a sense of aliveness through the descriptiveness of the prose or the use of precisely the right words, or by adopting a colloquial tone of voice, perhaps.

Living with Joy and Balance — Simplicity.

More and more, people feel that they are working too much, consuming too much, and rushing too much. There is no time for friends and family, no time for community and creativity, any time for a sense of connectedness with the rest of life. The Simplicity movement is a response to this dilemma. It is about living consciously in order to live more fully, thinking through the effects of our behaviors in terms of the consequences for the well-being of people and the planet. It's about asking what's important what matters. It's about redefining the "good life."

The concept of Simplicity is not, as some might think, a life of "self deprivation." It is a turning away from activities that have failed to deliver satisfaction— activities such as shopping and scrambling up the career ladder — in order to embrace activities that bring true joy and meaning — creativity, community, and the celebration of daily life. Simplicity is "the examined life" in which we explore not only what creates fulfillment in our personal lives, but we ask which public policies create societies of justice and environmental well-being. Simplicity touches all aspects of our lives, including the issues of time, work, vocation, community, spending, consuming, health, social justice, and spirituality. Across the country, people are joining simplicity study circles.

The study circle is a small group, peer-led egalitarian form of self education and social change. It's a form of social innovation used extensively in Sweden where study circles are referred to as "education by the people, for the people, and of the people". Sweden has been called a "study circle democracy," and indeed research has found that people who participate in a study circle are apt to be more involved in the common good, regardless of the topic of the study circle. Simplicity study circles are designed to help people discuss the idea of Simplicity and to make concrete changes in their lives. Simplicity study circles are at once a support group, a discussion group, and a method of behavioral change. They focus on building community, creating support for personal change, and engaging in critical thinking for societal change. Topics addressed include Finding More Time, Creating Community, Finding Your Passion, Transforming the Workplace, Reducing Your Consumerism, Creating Healthier Life Styles, Linking Simplicity to Social Justice, Exploring and Defining One's Spirituality. Simplicity study circles are designed for maximum participation and a minimum of competitiveness within an ethos of acceptance and caring.

People today often experience their lives as lacking vitality or purpose and are looking for the experience of aliveness and depth. Too often people's spirit has been broken; their uniqueness suppressed. By reflecting on their own lives, people can discover their own particular "passion," something they love to do, and something that brings them a sense of direction, a sense of joy and fulfillment, and maybe something from which they can earn money.A basic human need is the experience of community — feeling valued, accepted, cared for and recognized for your true self. Without joyful, exuberant conversation we feel isolated and depressed and pursue the empty paths of shopping and watching television.

METHODOLOGY

Statement of the problem

The effect of age on uniqueness, simplicity and aliveness among old age people

Objectives of the study

1. To study the uniqueness, simplicity and aliveness among old age men and women.
2. To compare the uniqueness, simplicity, aliveness among old age men and women.

Hypothesis

H1. There is a significant difference in aliveness, uniqueness, simplicity among old age men and women.

H2. There is a significant difference between uniqueness, simplicity and aliveness among pension and non-pensioned old age people.

Variables

Dependent variable: old age people.

Independent variable: uniqueness, simplicity and aliveness

Sample size

A Sample of 210 old age people, are selected for the present study.

The sample consists of 210 old age people from Hassan old age home. In 210, 105 pensioned and 105 non pensioned old age people, the data collected in random method.

Design: quasi experiment design.

Materials: The peak experience scale. Mathes et al., 1982, consists of 70 true – false items.

Statistical analysis

Statistical techniques used for analysis. The researcher after collecting the data, the data were edited and coded. The data were then analyzed using various statistical tools like, mean, SD and t-test.

DATA ANALYSIS

Table: 1. Mean, SD and t-value of Aliveness in men and women.

Group	Men	Women
Mean	16.20	12.68
SD	2.50	2.88
SEM	0.50	0.58
N	25	25
t-value	4.61	
p-value	0.0001	

Above table shows Mean, SD and t-value of aliveness in men and women old age people. The mean and SD of men is 16.20 and 2.50. it is score indicates male have higher the aliveness. Than

the female is 12.68 and 2.88 respectively. Above score indicates that, men have below normal in aliveness and women have very poor in aliveness. It shows that, both have supering from old age aliveness in their daily life. The calculative t-value is 4.61 it is higher the table value 0.001. the level of significant.

The formulated hypothesis is that "there is significant difference between men and women old age people In their aliveness." Hence the formulated hypothesis accepted.

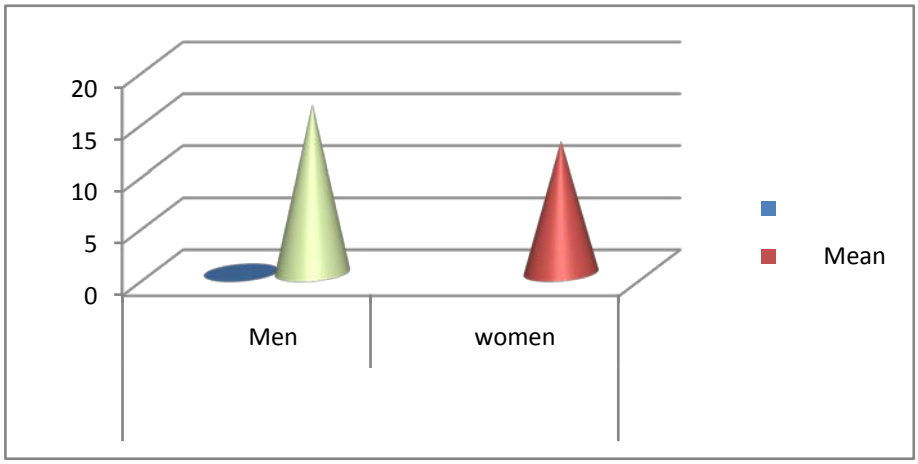


Table:2 Mean, SD and t-value of simplicity in men and women.

Group	Men	Women
Mean	13.44	10.72
SD	2.81	2.15
SEM	0.56	0.43
N	25	25
t-value	3.54	
p-value	0.0005	

Above table shows Mean, SD and t-value of Simplicity in men and women old age people. The mean and SD of men is 13.44 and 2.81. it is score indicates male have higher the Simplicity. Than the female is 10.72 and 2.15 respectively. Above score indicates that, men have below normal in Simplicity and women have very poor in Simplicity. It shows that, both have suffering from old age Simplicity in than daily life. The calculative t-value is 3.54 it is higher the table value 0.0005. the level of significant.

The formulated hypothesis is that "there is significant different between men and women old age people in their Simplicity. Hence the formulated hypothesis accepted.

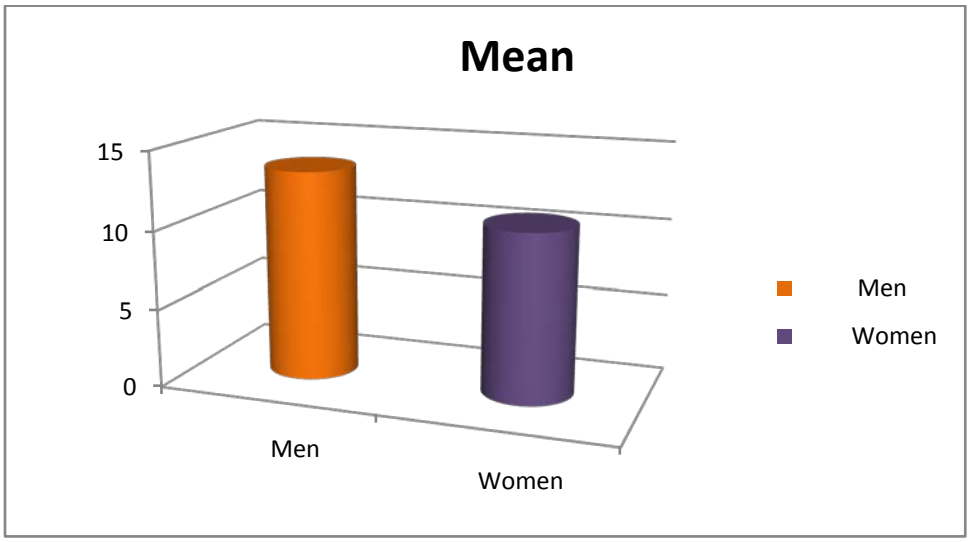


Table:3 Mean, SD and t-value of uniqueness in men and women.

Group	Men	Women
Mean	9.72	13.44
SD	4.92	2.81
SEM	0.98	0.56
N	25	25
t-value	3.2812	
p-value	0.0001	

Above table shows Mean, SD and t-value of uniqueness in men and women old age people. The mean and SD of men is 9.72 and 4.92. it is indicates female have higher the uniqueness. Than the female is 13.44 and 2.81 respectively. Above score indicates that, men have below normal in uniqueness and women have very poor in uniqueness. It shows that, both have sparing from old age uniqueness in their daily life. The calculative t-value is 3.2812 it is higher the table value 0.0001 level of significant.

The formulated hypothesis is that "there is significant different between men and women old age people In their uniqueness." Hence the formulated hypothesis accepted.

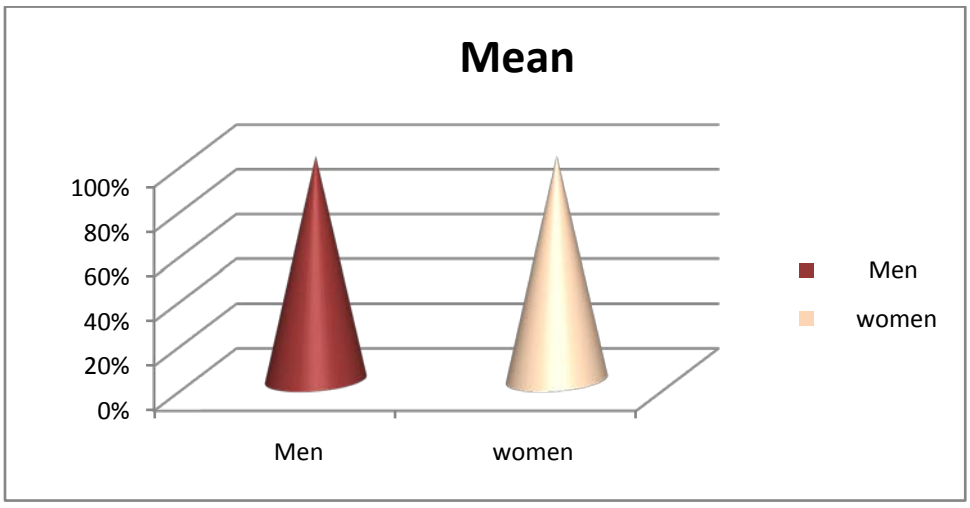


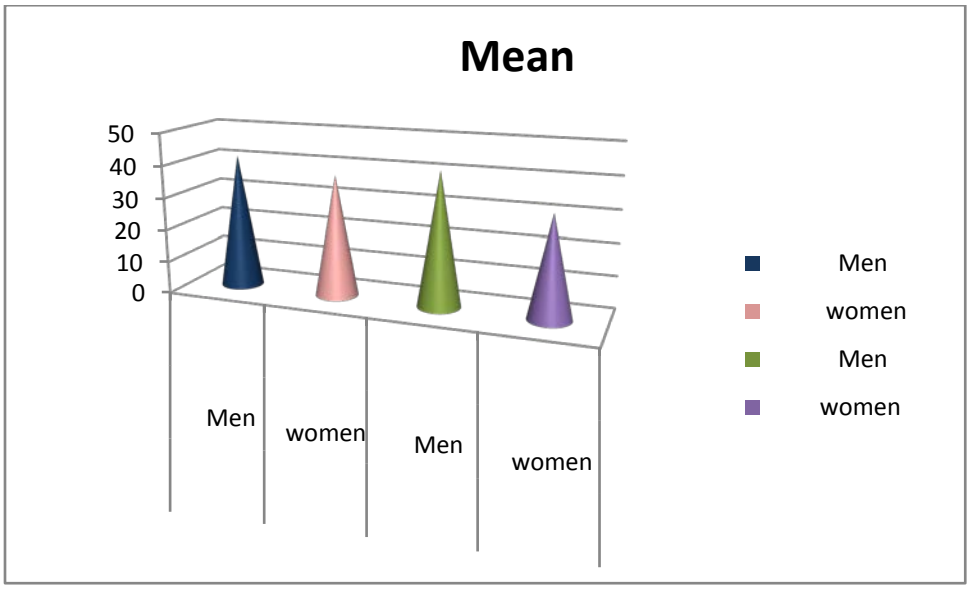
Table:4 Peak Experience in men and women

	Pension		non-pension	
Group	**Men**	**Women**	**Men**	**Women**
Mean	41.60	37.60	41.27	31.47
SD	4.45	6.41	4.01	11.06
SEM	1.15	1.66	1.03	2.86
N	15	15	15	15
t-value	1.9517		3.22	
p-value	0.05		0.001	

Above table shows Mean, SD and t value of pension and non pension in men and women old age people. The pension mean and SD of mean is 41.60 and 4.45. it is score indicates men have higher the peak experience. Than the female is 37.60 and 6.41respectively. above score indicates that men have below normal in peak experience and women have very poor in peak experience. It shows that, both have sparing from old age peak experience in their daily life. The calculative t-value is 1.9517 it is higher the table value 0.005 level of significant.

The non pension mean and SD of mean is 41.27 and 4.01. it is score indicates men have higher the peak experience. Than the female is 31.47 and 11.06. Respectively Above score indicates that men have below normal in peak experience and women have very poor in peak experience. It shows that, both have sparing from old age peak experience in their daily life. The calculative t-value is 3.22 it is higher the table value 0.001 level of significant.

The formulated hypothesis is that “there is significant difference between men and women old age people. In their peak experience”. Hence the formulated hypothesis accepted.



SUMMARY AND CONCLUSION

- There is significant difference between men and women old age people in their aliveness.
- The score indicates that men have below normal in aliveness and women have very poor in aliveness in their daily life.
- There is significant different between men and women old age people in their simplicity.
- The score indicates that, men have below normal in simplicity and women have very poor in simplicity in their daily life.
- There is significant difference between men and women old age people in their uniqueness.
- The score indicates that, men have below normal in uniqueness and women have very poor in uniqueness in their daily life.
- There is significant difference between pensioned and non-pensioned old age people in their peak experience.
- The pension score indicates that men have below normal in peak experience and women have very poor in peak experience in their daily life.
- The non-pension score indicates that men have below normal in peak experience and women have very poor in peak experience in their daily life.

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Quality of Life in Schizophrenia and Bipolar Affective Disorder

Pratima[1]*

ABSTRACT

Family caregivers of persons with bipolar disorder and schizophrenia experience high level of burden and compromised quality of life. A considerable amount of burden on the caregivers often leads to display of certain attitudes towards persons with severe mental illness called expressed emotion, which then leads to poor quality of patients as well. Although numerous studies dealing with these issues separately are present, but studies dealing with relationship, using mixed methodology, among these issues are scarce. The aim of the present study was to understand how actually the construct of quality of life in different demographic conditions affect life conditions of schizophrenic and bipolar patients and determining relapse. The present study was designed mainly to assess the quality of life on patients and the families of a particular group of patients namely those with schizophrenia and bipolar disorder. The objectives if the present research were to study: (i) the quality of life of patients with Schizophrenia and Bipolar Affective disorder. (ii) the quality of life of caregivers of patients with Schizophrenia and Bipolar Affective disorder. Patients with disorders such as schizophrenia and bipolar affective disorder are more likely to relapse when there is high expressed emotion present in their living environment. The stress from the remarks and attitudes of the family is overwhelming because they feel like the cause of the problems. The patient then falls into the cycle of relapse. The only way to escape this vortex for the family is to go through therapy together to prevent the relapse. But before that it becomes necessary to understand that what is the reason behind such attitude towards a family member who is mentally ill, what is the cause of burden and what all changes the caregivers' and the patients' quality of life come across.

Keywords: *Quality, Life, Schizophrenia, Bipolar Affective*

In the scientific literature, the term quality of life is used with many different meanings and refers to a loosely related body of work on psychological well- being, social and emotional functioning, functional performance, life satisfaction, social support etc. The study of quality of life and the focus on patient's subjective sense of well- being is a fairly new phenomenon that has attracted professional attention only within the past two decade. Between 1850 and 1950, medicine was dominated by the quest for cures; treating chronic illness as well as helping patients manages long-term impairment received less attention. Issues of life quality that cannot

[1] Assistant Professor, Amity Institute of Psychology and Allied Science, Amity University, Noida, U.P
*Responding Author

be eliminated must be managed and the treatment goal becomes maintaining maximum functioning and a meaningful existence or quality of life. With the increasing awareness of the multidimensionality of the treatment outcome and the importance of patient satisfaction in health care, the construct of quality of life has become an important area of investigation. Especially the interest in quality of life in psychiatry has been stimulated by the deinstitutionalization of psychiatric patients as well as a parallel interest in understanding the scope of their daily lives. Studies also focused on the quality of life rather than cure of illness in psychiatric patients living in community (Brown et. al. 1998). Doyle et. al. (1999) also identified quality of life as an important measure of impact of schizophrenia and its respective treatment.

Quality of Life and Mental Illness

Mental and behavioral disorders cause massive disruption in the lives of those who are affected and on their families. Quality of life of persons with severe mental illness would be substantial and sustained due to its negative impact on the illness. Studies also showed that individuals with severe mental illness living in long term institutional set up had poorer quality of life than those living in the community (Olweny, 1992). One of the study demonstrated that unmet basic social and functioning needs were the largest predictors of poor quality of life among individuals with severe mental disorder (Olweny, 1992). According to Patrick & Erickson (1993), life has two dimensions: quality and quantity. Quantity of life is expressed in terms of hard biomedical data such as mortality rates or life expectancy. Quality of life refers to complex aspects of life that cannot be expressed by using only quantifiable indicators; it describes an ultimately subjective evaluation of life in general. It encompasses, though not only the subjective sense of well being but also objective indicators such as health status and external life situations.

Mental illness in the home can affect not only the quality of family life but also the health of the family members. A stressful emotional climate, anxieties and practical burdens, can have harmful effects a on the physical and mental health of both adults and children. Children as well as adults experience adverse effects on their health and this possibility has been studied extensively. An important consideration is that if children's mental and physical health is affected, with possible long-term consequences, then the social costs of having mentally ill people in the home may be very high (Rutter et. al., 1976). Mental disorders involve suffering. If the illness is chronic, the individual may have struggle with his or her identity (*what kind of person am I?*) and with alterations in lifestyle (Charmaz, 1995). Protracted or chronic illness also affects the rest of the family. Taking care of a chronically ill individual is demanding and stressful. The marital relationship may suffer (Woods & Lewis 1995). Family patterns may have to be altered and may be highly constrained by the sick member.

One reason for serious illness tends to disrupt family life is that it *precludes proper role functioning*. For example, those who are physically or emotionally ill may be incapable of adequately fulfilling the roles of spouse, parents, or, breadwinner. The normal functioning of family life may give way to a focus on the ill person. In extreme cases, most activities of family members reflect the ill person's needs and limitations. Poor interpersonal relationships can be a

factor in the onset of a mental disorder, and mental disorders adversely affect interpersonal relationships (Palisi and Canning 1983). In sum, there is a relationship between patterns of interaction and healthy. Illness, weather physical or mental, tends to be associated with disturbed interpersonal relationship. The relation between interaction and illness may be a vicious circle: bad interpersonal relationships being a factor in the onset of illness, and illness being a factor in causing disturbed relationships. The inadequate care of the mentally ill has been compounded by deinstitutionalization movement that began in the mid-1950s (Lamb 1998). At that point, in part because of the new drugs that were available, state and country hospitals began discharging a great many patients, some of whom had serious mental disorders. Unfortunately, the reality diverged sharply from the ideal, with the result that the movement added to the problem of inadequate care (Wright, Avirappattu, and Lafuze 1999).

Research Related to Quality of Life

Broadly, quality of life is a person's sense of wellbeing and satisfaction with his or her life circumstances as well as a person's health status and access to resources and opportunities. Unfortunately, the factors that influence quality of life in schizophrenia and affective disorder are not well known. One such factor consistently shown to be negatively associated with quality of life is psychiatric symptoms (Lambert & Naber, 2004). However, due to wide variations in measurement strategies and definitions of quality of life, it has been difficult to identify which psychiatric symptoms are most strongly associated with poor quality of life in individuals with schizophrenia and affective disorders.

Quality of Life in Severe Mental Illness

There is need to focus to determine the factors associated with or affecting subjective quality of life in people with severe mental illness. Hansson (2006) stated that subjective quality of life in people with severe mental illness is only to a lesser extent related to external life conditions. Major determinants are psychopathology, especially symptoms of depression and anxiety, and aspects of social network. Personality related factors such as self esteem are also influential. Comparative studies have further shown that patients in community care settings have a better subjective quality of life than patients in hospital settings (Hansson, 2006). Evans et al. (2006) reported that objective life conditions were worse in the severe mental disorder group than in mentally healthy population. Severe mental illness population scored low on overall subjective and objective quality of life than group with no mental disorder. There are negative effects of distress/ clinical factors (psychological distress, anxiety, depressive and negative symptoms) on quality of life of psychiatric patients (Ritsner et al. 2003). There is increasing evidence which suggests that psychosocial or stress process is related rather than clinical factors more accurately predict quality of life. People with long-term psychiatric illness are so disabled and impaired that they are difficult to be placed in the community. In a study done by Young (2004) explored the impact of a residential home on the quality of life of people with long- term mental illness after their discharge from mental hospitals. This research adopted a combined research methodology and quality of life data were obtained from both quantitative and qualitative analysis. This research study has demonstrated that residential home care can lead to a better quality of life,

including both subjective and objective quality of life of people with long- term psychiatric illness.

Schizophrenia: Impact on Quality of Life

Many researchers attempted to study poor quality of life in schizophrenia despite significant improvement with pharmacological treatment. In one such research done by Solanki et al. (2008) studied quality of life in patient with schizophrenia and determined influence of clinical factors and socio- demographic variables on quality of life of schizophrenia patients. Social relationship domain of quality of life was significantly negatively correlated with occupation with employed patients reporting better quality of life in this domain. Overall scores on positive and negative symptom scale (PANSS) was significantly negatively correlated with physical, psychological, social relationship domains and total quality of life. Sullivan and others (1992) also noted that long term psychiatric disorders such as schizophrenia are more vulnerable to stress, are more dependent, have greater deficits in living skills and have greater problems in employment and in relationship to their social environment. They also reported that quality of life of chronic psychiatric patients (heterogeneous groups including patients with schizophrenia, chronic affective disorders, personality disorders, substance abuse, etc.) is impoverished especially in the domains of housing conditions, family environment, social network, financial circumstances, safety and practical skills.

Several studies have confirmed poor quality of life in schizophrenia despite significant improvement with pharmacological treatment. Gee et al. (2003) addressed the dearth of qualitative research by conducting a small-scale qualitative exploration of the impact of schizophrenia on quality of life. Ten quality of life domains were identified as being important: (1) barriers placed on relationships; (2) reduced control of behaviors and actions; (3) loss of opportunity to fulfill occupational roles; (4) financial constraints on activities and plans; (5) subjective experience of psychotic symptoms; (6) side effects and attitudes to medication; (7) psychological responses to living with schizophrenia; (8) labelling and attitudes from others; (9) concerns for the future and (10) positive outcomes from experiences. Domains identified by participants encompassed a wide range of factors that may be expected to contribute generally to engaging in a positive quality of life. Participants identified that it was the loss of these things as a direct consequence of having schizophrenia that influenced their quality of life. It would appear that in the main, factors that are secondary to the experience of schizophrenia are of most importance to participants. The relationship of personal characteristics, objective indicators, and self-esteem to quality of life (QOL) was investigated (Kunikata et al., 2005). Depressive mood and uncooperativeness were negatively correlated with self-esteem, and self-esteem was positively correlated with QOL. Self-esteem was considered to directly affect quality of life, and depressive mood and uncooperativeness to affect quality of life via self-esteem. Findings suggest that, in order to improve the quality of life of schizophrenia patients, interventions to help alleviate psychiatric symptoms (e.g. depressive mood, uncooperativeness) must be utilized. Subjective quality of life and psychosocial functioning constitute important treatment outcomes

in schizophrenia. Brissos et al., (2011) in their study mentioned that greater symptom severity and worse insight were significantly associated with worse functioning in all quality of life domains. Symptoms were more moderately correlated with quality of life, with no significant correlations between quality of life and positive symptoms and insight levels. Symptom severity may exert a greater influence on social functioning than on subjective quality of life; however, social functioning was not associated with subjective quality of life.

Quality of Life in Bipolar Disorder

The cyclical nature of bipolar disorder, with its many remissions and symptom rich periods of exacerbation, can affect an individual's physical, emotional, social and functional well-being and significantly impact their overall quality of life. In a study Vojta and colleagues (2001) hypothesized that patients with manic symptoms would report significantly lower quality of life than would patients who were euthymic. Patients with mania/hypomania did show significantly lower mental health scores than euthymic patients with depressed or mixed patients showing significantly poorer QOL again. An attempt for qualitative study was made by Michalak et al. (2006), identified themes in the quality of life influences of bipolar disorder. Respondents described a wide variety of factors that influenced quality of life including adverse effects of medications, occupation, and level of education, physical functioning, environment, health care factors, leisure activities, routine and sexuality. Overall, those individuals described having undergone several years of hardship and adjustment. Some of the factors mentioned (e.g. Independence, stigma, and disclosure, identity and spirituality) are not frequently examined in relation to quality of life, yet they appear to have a significant impact on people's ability to lead full lives in the context of bipolar disorder. Several studies have also found that quality of life is compromised in people with bipolar disorder, even during period of clinical remission. Cooke and colleagues (1996) in their study reported that patients with bipolar-II reported significantly poorer quality of life than bipolar-I in the areas of social functioning and mental health. WHO estimates, bipolar disorder was the 6th leading cause of disability worldwide among young adults at the turn of the century. For e.g., if bipolar disorder develops in a woman at the age of 25, she may lose 9 years in life expectancy (because of cardiovascular and other medical problems), 14 years of productivity and 12 years of good health (US DHEW Medical Practice Project 1979). Disturbingly the lifetime suicide rates of patients with bipolar disorder (treated or not) may be as high as 15%. Calabrese et al. (2003) reported that bipolar symptoms have been associated with significant functional impairment, often having a negative impact on the performance of work related, leisure, and interpersonal activities. Many studies have also found that quality of life is compromised in people with bipolar disorder, even during period of clinical remission [(Arnold et al. 2000).

Euthymic patients are not necessarily a symptomatic as many have mild sub- syndromal symptoms, and several studies demonstrated that even residual depressive symptoms can be strongly associated with impaired quality of life. The relationship between quality of life and hypomania is less well understood. Both mania and hypomania can be associated with

substantial depressive symptomatology, either in the form of 'dysphoric mania/ hypomania' or when the patient experiences a mixed episode. This understanding led Vojta and colleagues (2001) to hypothesize that patients with manic symptoms would report significantly lower quality of life than would patients who were euthymic. Patients with mania/ hypomania did show significantly lower mental health scores than euthymic patients with depressed or mixed patients showing significantly poorer QOL again (Sierra et al., 2005). Gazalle et al., (2007) evaluated the influence of manic symptoms on quality of life in a sample of adult bipolar disorder (BD) patients. Das et al. (2005) recently found that patients who screened positive for bipolar disorder had lower mental and physical quality of life scores than those who screened negative. Interestingly, some studies have demonstrated lower levels of quality of life in bipolar depression in comparison with unipolar depression. Levels of depressive symptoms (Vojta et al., 2001; Yatham et al., 2004; Sierra et al., 2005), female gender and time undiagnosed (Gazalle et al., 2007), have been put forward as predictors of worse quality of life in bipolar disorder samples. The association between socio-demographic characteristics and quality of life was found for gender, age, education, and employment status and living arrangement (Caron et al., 2005).

Several quantitative studies have now examined the relationship between quality of life and bipolar disorder and have generally indicated that quality of life is markedly impaired in patients with bipolar disorder. However, little qualitative research has been conducted to better describe patients' own experiences of how bipolar disorder impacts upon life quality. Michalak et al., (2006) stated that clinical characteristics of the affected sample ranged widely between individuals who had been clinically stable for several years through to inpatients who were recovering from a severe episode of depression or mania. Findings indicated that there is a complex, multifaceted relationship between bipolar disorder and quality of life. Most of the affected individuals we interviewed reported that bipolar disorder had a profoundly negative effect upon their life quality, particularly in the areas of education, vocation, financial functioning, and social and intimate relationships.

Co-morbidity with Schizophrenia and Bipolar Disorder and Quality of Life

The clinical presentation of bipolar disorder is usually associated with psychological suffering, functional Impairment, interpersonal problems and substantial burden. Bipolar patients with higher scores for depression were reported to present lower scores for quality of life. Anxiety is a frequent complaint among patients with bipolar patients, and anxious co-morbidities are more prevalent among patients with bipolar disorder than among patients with unipolar depression. Anna et al. (2007) assessed the impact of anxiety co-morbidity on quality of life of patients with bipolar disorder. Anxiety co-morbidity in bipolar patients was associated with lower scores in all domains of quality of life. Current anxiety co-morbidity was also associated with lifetime alcohol abuse and dependence, rapid cycling, lifetime psychosis, number of suicide attempts, and a lower score in the Global Assessment of Functioning measure.

Co-morbidity of psychiatric disorders plays a major role in poorer quality of life in schizophrenia disorder. Bache, (2008) studied to determine the relationship between symptoms of obsessive-

compulsive disorder (OCD) co-morbid with schizophrenia, and QOL and functioning. Functionality and social relationships domains in schizophrenia- OCD patients showed similar patterns with schizophrenia only patients. Severity of psychotic symptoms was correlated with functionality but not with total quality of life scores in schizophrenia- OCD patients. Beside, severity of OCD symptoms was related with social relationships domain of life quality in schizophrenia- OCD group patients.

Comparison of Quality of Life in Bipolar Disorder and schizophrenia

Long term psychiatric disorders such as schizophrenia, and bipolar disorder are more venerable to stress, are more dependent, have greater deficits in living skills and have greater problems in employment and in relationship to their social environment. (Sullivan & colleagues, 1992). They also reported that quality of life of chronic psychiatric patients (heterogeneous groups including patients with schizophrenia, chronic affective disorders, personality disorders, substance abuse, etc.) improvised especially in the domains of housing conditions, family environment, social network, financial circumstances, safety and practical skills.

Disability has been noticed by many researchers in long standing disorders such as BPAD, Schizophrenia, and recurrent depressive disorder (RDD) in a study done by Tarrier and Turpin (1992) compared the inter-episode quality of life and disability in patients with severe mental illness (schizophrenia, bipolar disorder, RDD) in remission with or without co-morbid medical illness. Disability score in bipolar group was significantly more in 'social role' and in the RDD group it was more in 'home atmosphere' with chronic co-morbid medical illness. In another group without co-morbid chronic medical illness, the bipolar group has significantly more disability in 'overall behavior' and 'social role', and the RDD group had significantly more disability in 'assets and /or liabilities' and 'home atmosphere' domain. It becomes clear from the study that chronic medical illness does not cause a difference in the quality of life between the two disorders. Schizophrenia is classically described as a disease of exacerbations and remissions, patients seldom returning to their per-morbid level of functioning after each episode. Recent opinions, however, dispute the contention that patients with schizophrenia invariably have a deteriorating course of illness. Over their life-time the range of recovery varies greatly; as reasonable estimate is that 20- 30% of patients continue to experience moderate symptoms and 40- 60% remain significantly impaired throughout life (Sim et al., 2004). Increased negative symptoms were particularly correlated with dysfunctional performance at work and socially. The widely held belief about mood disorders is that these disorders are readily treated, and that once treated they require little or no intervention. But epidemiological studies of mood disorders suggest that there is significant chronicity. Atkinson et al. (1997) in their study characterized the quality of life of the three patient groups with chronic mental illness and evaluated differences in reported life quality among the three groups. The study groups consisted of chronically mentally ill patients with schizophrenia (n= 69), bipolar disorder (n= 37) and MDD (n= 35). Subjects were administered the quality of life index, and comparisons of both objective and self report life quality indices were made among the three groups. Results showed that two groups with mood

disorders reported significantly lower scores on quality of life index than the patients with schizophrenia. Moreover, the scores on the quality of life index for patients with schizophrenia were very similar to those of the comparison group of physically ill patients. The opposite trend emerged when groups were compared with respect to objective indicators of life quality. Schizophrenic patients experienced moiré objectively aversive life circumstances than either of the affectively disturbed groups.

Many researchers attempted to compare quality of life of bipolar disorder and schizophrenics patients with normal population. Among such studies, Rojas et al. (2008) evaluated those patients with bipolar disorder present worse mental health and quality of life than the general population. Davenport (2008) replicated similar results. Author explained that bipolar disorder patients who are in remission might still experience sub-syndromal or residual symptoms, which can lead to impairment and disability. They reported that bipolar disorder patients had consistently lower quality of life than general population with significant difference observed on the physical health, psychological health and social relationships domain. (Young, 2004; Davenport, 2008). Rojas et al. (2008) in his study evaluated the quality of life of patients suffering from bipolar disorder in comparison with the general population. It was discovered that patients with bipolar disorder present worse mental health than the general population; in addition, bipolar disorder patient have a poorer quality of life at a physical level. This could be due to a higher consumption of addictive substances such as alcohol and tobacco, the long- term secondary effects of the pharmacological treatment and a more sedentary way of life. The research also suggests that people with bipolar disorder who suffer a low quality of mental life are those who started to suffer the disease before 20 years old, who have been suffering it for a longer time, who suffer the II subtype of the disease, who are dependent on tobacco and who are suffering depressive symptoms at present. Furthermore, work has made clear that depressive symptoms (sadness, listlessness, tiredness, concentration difficulty, insomnia, poor appetite, etc.) have a higher impact on quality of life than manic symptoms (excessive self-esteem, lack of inhibition, verbosity, hyperactivity, increase of sexual appetite, etc.). depressive symptoms also produce more disability or negative repercussions for work, family and social life; this observation reflects the fact that manic symptoms are usually shorter in time and have a good response to medication, whereas depressive one are usually more difficult to eliminate (Arnold et al. 2000). In the past, the first goal of bipolar disorder treatment was the reduction of symptoms of mania or depression, rather than the recovery of social functioning. Recently, as a result of an increased emphasis on patient needs, the concept of quality of life has been brought into the treatment of physical illnesses. Klara et al., (2011) examined quality of life data in patients with bipolar disorder in clinical remission and to determine the extent of the effects of demographic and clinical data on quality of life in these patients.

Predictors of Poor Quality of Life in Schizophrenia and Bipolar Disorder

Schizophrenia is a severe and debilitating disorder, which affects general health, functioning, autonomy, subjective wellbeing, and life satisfaction of those who suffer from it. Despite 50 years of pharmacological and psychological intervention. Schizophrenia remains one of the top causes of

disability in the world. Numerous studies on the correlates and predictors of quality of life in schizophrenic patients have been performed. Among many factors affecting objective quality of life, the importance of psychopathological symptoms especially negative and general psychopathology [(Addington et al. 2003), (Brown et al. 2000), (Priebe et al. 2006)], duration of untreated psychosis (DUP), pre-morbid social adjustment (Browm et al. 2000), social support and demographic variables (age, gender) have been emphasized. The subjective quality of life of schizophrenic patients is described as associated with depression, anxiety, negative, and rarely positive symptoms [(Bechdolf et al. 2003), (Sim et al. 2004)]. Other studies have related to the role of social support [(Caron et al. 2005)], DUP and stress related factors (Ritsner et al. 2006). Most previous studies on factors affecting quality of life were cross sectional, included patients with various durations of illness, and analyzed only one of the two dimensions of quality of life. Factors related to subjective quality of life in schizophrenia have been extensively reported. Brown et al. (1996) found that length of illness and the cumulative duration of hospitalization significantly correlated with SQOL. Law et al. (2005) reported that SQOL was more related to negative symptoms and only weakly related to, or independent of, positive symptoms.

Psychopathological symptoms are responsible for subjective and objective quality of life. Among psychopathological symptoms, negative symptoms seem to play the most important role in objective quality of life, especially for the social engagement/ withdrawal and independence performance domains. Socio-demographic factors put little influence on functioning in the majority of domains of quality of life. The influence of subjective quality of life increases with duration of post hospitalization period due to increase in negative symptoms over the period of time (Bechdolf et al., 2003). Sierra et al. (2005) assessed the quality of life in bipolar patients, and analyzed a set of clinical variables and socio-demographic data that could act as quality of life predictors. The study concluded that bipolar patients experience lower functioning and well-being even in the stable phase of the disorder. There is growing evidence that the deleterious impact depressive episodes and sub-threshold depressive symptoms in bipolar disorder extends to quality of life and functioning [(Vojta et al. 2001), Altshuler et al. 2002)]. Altshuler and colleagues (2006) found that sub-threshold depressive symptoms of bipolar disorder were significantly predictive of impaired role functioning- specifically, impairment in work, home functioning, and relationships (Yatham et al. 2000).

A study done by Awad et al. (2007) aimed to quantify the prevalence of misdiagnosed bipolar disorder among the depression population and evaluate the quality of life impact on misdiagnosis. The misdiagnosis in associated with poorer quality of life than major depressive disorder or diagnosed bipolar disorder, which are recognized as having a considerable impact on quality of life. In a naturalistic longitudinal study conducted by Ritsner et al., (2003) determined predictors of perceived quality of life and explored changes that occurred regarding quality of life among schizophrenics and bipolar patients. Poor quality of life was not a more severe problem for schizophrenic than for bipolar patients. Improved quality of life of schizophrenics was associated with reduced paranoid and distress (obsessive and somatization) symptoms and

increased self- efficacy and self- esteem ratings. Individual changes in quality of life index scores among bipolar patients were associated with changes in depression, sensitivity, expressed emotion, and task- oriented coping scores.

Quality of life of Caregivers

Schizophrenia and bipolar disorder are an "unending burden" on the family. Caring for a person with chronic mental condition is more stressful than caring for a person with a physical disorder or disability. The effects on family carers are diverse and complex and there are many other factors which may exacerbate or ameliorate how carers react and feel as a result of their role. Caregiving is uniquely stressful event. Being a long-term caregiver has been found to be associated with a variety of negative outcomes. The consensus among studies examining physical and mental health outcomes is that a majority of caregivers report feeling physically and emotionally distressed (Anthony- Bergstone, Zarit & Gatz, 1988; Brodaly & Hadzi Pavlovie, 1990; Clipp & George, 1990b). Several studies report higher levels of psychological morbidity among caregivers compared to no caregiving samples of the populations. Anthony- Bergstone and her colleagues (1988) noted the increased feeling of hostility, anger, and anxiety among caregivers as compared to the general population. Women caregivers' generally report higher levels of psychological distress than men (Anthoney- Bergstone et al., 1988). The studies have found that caregivers frequently meet diagnostic criteria for depression or other diagnosis. In one of the most comprehensive studies of this kind. Studies found prevalence rate for depression ranging from 31% for men to 46% for women. These studies provide strong evidence that caregivers are at risk of increased psychiatric symptoms and clinical disorders. Carers, who are women, and those who are spouse, have higher rates of psychological morbidity, perhaps because of the increased stresses inherent in being married to a person with schizophrenia or bipolar disorder (Jungburer, 2004).

Carers who cohabitate are more likely to be depressed or psychologically stressed than those living apart (Broadly & Hadzi- Pavlovic, 1990; Harper & Lund, 1990). The gender of the patient does not appear to affect carer well- being is made for the increased likelihood for behavioral disturbances in men (Broadty & Hadzi- Pavlovic, 1990). There have been no consistent associations found between carer age and psychological distress, with higher levels having been reported in older carers and in younger supporters. However, such comparisons need no control for the effects of relationship in looking at age (Brodaty & Hadzi-Pavlovic, 1990; Draper et al., 1992). The relationship between behavioral disturbances in patient and caregiver depression (Brodaly & Hadzi Pavlovic's 1990). Haley & Pardo, 1989, however revealed a significant correlation between depressive mood ratings in carers and demand behavior in patient, although disturbance problems (accusations, temper outbursts, bad language, and aggression) showed no association. Baumgarten et al., 1992) employed large numbers of subjects and used multivariate procedures to analyze this relationship and reported a strong positive relationship between caregiver depression and aspects of aspects of behavioral disturbances in patient. Numerous studies have demonstrated that increased psychological morbidity in carers (Garfstrom &

Winbald, 1995; Brodaly & Hadzi- Pavlovic, 1990). Depression levels and rates are also high (Rosenthal et al., 1993; Gallagher et al., 1989).

Carers have poorer physical health than non-carer controls, higher levels of chronic conditions, prescription medications and doctor visits (Haley 1989) and more physical symptoms and poorer self-rated health. Those with poor psychological health are even more likely to have physical morbidity (Brodaly & Hadzi- Pavlovic, 1990; Vehars et al., 1999). They concluded that carers may be vulnerable to infectious disease. Other indicators of poorer physical health are increased such as service use hospitalization, physician visit, drug use, aggregate use of health services, and less healthy behavioral as reflected by use of alcohol, smoking , sleep patterns, eating behavior and nutrition. Further, pre-existing conditions such as hypertension are more likely to be exacerbated by the care giving role. In a Sudanese study conducted by Awadalla et al., (2005) assessed subjective quality of life of caregivers of schizophrenia, affective disorder and neurosis using WHOQOL- BREF. Schizophrenia caregivers had lower scores than others. Caregivers' socio- demographic variables were significantly associated with quality of life. Their quality of life was predicted by their impression of patients and state of health. Spouses of people with mental disorder experience various forms of objective and subjective burden. This should negatively affect their quality of life. Angermeyer et al., (2006) investigated the quality of life of spouses of people with schizophrenia, depression or anxiety disorders. When compared with the general population, the quality of life of the spouses of mentally ill people was lower in the domains 'psychological well-being' and 'social relationships'. There was a significant association between the patient's functional level and the spouse's quality of life. In addition to the stress spouses are exposed to during acute episodes of illness, spouses also experience chronic burdens in their everyday life which can severely affect their living situation and well-being: insecurity and ambivalence in the relationship with the patient, changes regarding intimacy and familiarity, shifts in role distribution, lack of opportunity for relaxing activities, sorrow and fears regarding the further course of the illness, impairment of health and financial strains (Jungbauer et al., 2004).

CONCLUSION

In conclusion we can say that mental illness in the home can affect not only the quality of family life but also the health of the family members. A stressful emotional climate, anxieties and practical burdens, can have harmful effects a on the physical and mental health of both adults and children. The role of family influences in causing and perpetuating the disorder of schizophrenia and bipolar affective disorder, therefore a need was felt to understand how actually the construct of expressed emotion and caregivers' burden operate in different cultures that is to say what components of expressed emotion and burden of care giving are determining relapse and poor quality of life in different cultural context. Patients with disorders such as schizophrenia and bipolar affective disorder are more likely to relapse when there is high expressed emotion present in their living environment. The stress from the remarks and attitudes of the family is overwhelming because they feel like the cause of the problems. The patient then falls into the cycle of relapse. The only way to escape this vortex for the family is to go through

therapy together to prevent the relapse. But before that it becomes necessary to understand that what is the reason behind such attitude towards a family member who is mentally ill, what is the cause of burden and what all changes the caregivers' and the patients' quality of life come across.

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Body Image Perceptions and Its Correlation with Self Esteem of Adolescents Studying In Engineering Colleges of Hyderabad

V. Divya[1]*, Dr. K. Mayuri[2]

ABSTRACT

The present study of Body Image Perceptions and its Correlation with Self Esteem of adolescents studying in engineering colleges of Hyderabad was made to know the relationship between Body Image Perceptions (skin complexion, facial features, blemish free skin, height, weight, etc.) and Self Esteem of adolescents. About 200 adolescents (100 boys and 100 girls) ranging from age group of 18 to 20 years were selected from engineering colleges of Hyderabad and Secunderabad regions of Telangana state. Body Image Perception scale and Rosenberg's Self Esteem scale were used to collect data and simple Pearson correlation was applied for selected population. The present study contributes to an emerging understanding of underlying relation between body image and self esteem. The findings reveal how the Self esteem is positively correlated with self assessment and perpetually inclined towards the overall assessment of Body Image Perceptions at 1% level of significance. The results presented will reveal the facts of effective correlation between the two considered variables of study.

Keywords: *Body image perceptions, self esteem, Adolescents, Complexion, Blemish free skin, Self assessment and overall assessment.*

Adolescence is a critical period of growth and emotional turmoil. During adolescence self perception about their appearance is important to the development of self esteem. Physical changes during puberty may cause them to have both positive and negative feelings towards their body which in turn affects their self esteem. Though there are many factors that influence adolescents' self esteem, body image is one critical factor (Paxton *et al.* 2006).Body image, the picture of the body that is formed in one's mind, is significantly influenced by the ever-changing interaction with the social environment. Self-esteem is often seen as a personality trait, which means that it tends to be stable and enduring. Self-esteem arises automatically from within based upon a person's beliefs and consciousness. Self-esteem and body image perceptions are the terms that are often used interchangeably to refer to evaluative perceptions of the self and physical appearance is critical for adolescent boys and girls development of self-confidence (McCabe and Ricciardelli, 2005). The link between body satisfaction and depression or low self-esteem was

[1] M.Sc. Department of Human Development and Family Studies, College of Home Science, PJTSAU, Saifabad, Hyderabad
[2] Emeritus scientist, ICAR, College of Home Science, PJTSAU, Saifabad, Hyderabad
*Responding Author

found across all adolescent age groups and experienced more by adolescent girls than adolescent boys (Van den Berg *et al.,* 2010)**.**The topic of body image has attracted a great deal of attention around the world especially in terms of art, psychological sciences and philosophy. While body image has been the focus of study in western countries, it is not extensively being studied in India especially on the dimensions like skin complexion, facial features, and blemish free skin and also about the relationship between body image and self esteem.

OBJECTIVE

To study the body image perceptions and its correlation with self esteem of adolescents studying in engineering colleges of Hyderabad

METHODLOGY

Research design

Based on the nature of the problem and objectives, ex-post facto research design was adopted for conducting this study. Since it is an unexplored area of study, simple survey method was followed to elicit the information.

Locale of the study

The study was conducted in twin cities of Hyderabad and Secunderabad in Telangana region. Locale was selected based on easy access and availability of permission from the colleges to collect data for the study.

Sampling procedure

Simple random sampling procedure was adopted in selecting the institutions and adolescents. Sample comprised of 200 adolescents with equal number of boys (100) and girls (100).
The sampling procedure included:

Criteria for sample selection

1. Age range of adolescents should be 18 -20 years
2. Students from Co-educational engineering colleges

Selection of institution

The list of four Co-education engineering colleges was selected based on accessibility and availability of permission from the colleges to collect data for the study, in Hyderabad and Secunderabad regions.

Selection of adolescents according to age

A list of engineering students with in the age range of 18-20 years was taken from the institutions. Adolescents were selected among defined age groups as follows.

Table 1. Selection of adolescents

S.no	Age	No of adolescents
1.	18	65
2.	19	65
3.	20	70
Total		200

Distribution of respondents

The total sample size of the study was 200, out of which 50 respondents were from each institution. The respondents were distributed in to boys and girls from 4 different fields of study.

Tools and Techniques

Self developed schedule on Body image perception and Rosenberg Self-Esteem scale were used to collect the data. The schedule was pre-tested and then applied in the present study with the control measures like handing over the scales one after the other in order to resist the anxiety of respondents in answering statements. This scale consists of seven domains, each domain measuring different aspects of body image perceptions of respondents. *Those are as follows*

1. General perception
2. Self assessment
3. My regrets about my body
4. My efforts to look the way I desire
5. Have you done any of the following things?
6. Ranking of appearance
7. Overall assessment

Statistical analysis

Simple Pearson correlation was used to study the correlation between self esteem and body image perceptions.

RESULTS AND DISCUSSION

Table 2. Self assessment of adolescents

S.No	Body part/Dimension	Total		
		Low S.A	Moderate S.A	High S.A
1	Height	12	35	153
2	Weight	22	50	128
3	Complexion	16	51	133
4	Skin texture	22	43	135
5	Hair length	21	46	133
6	Hair texture	17	42	141
7	Hair Colour	9	22	169
8	Chest measurement	18	46	136
9	Waist measurement	22	53	125
10	Hip measurement	19	51	130
11	Eye colour	13	20	167
12	Eye size	10	37	153
13	Nose shape	17	41	142
14	Ears Shape	9	23	168
15	Mouth shape	12	36	152
16	Neck shape	12	24	164
17	Shoulders	9	28	163

Self assessment in the study deals with adolescents ranking of them and associated level of satisfaction regarding different dimensions of their body. The results from Table 2, revealed that the three fourth of the respondents are satisfied and ranked themselves under high level of satisfaction on the dimensions like, hair colour, ears shape, eye colour, neck shape and shoulders, followed by height, eye size, mouth shape, nose shape, hair texture, skin texture and chest measurement. One fourth of respondents are moderately satisfied on the dimensions like weight, complexion, waist and hip measurements, only meagre number of respondents can be placed on low level of satisfaction under different parameters.

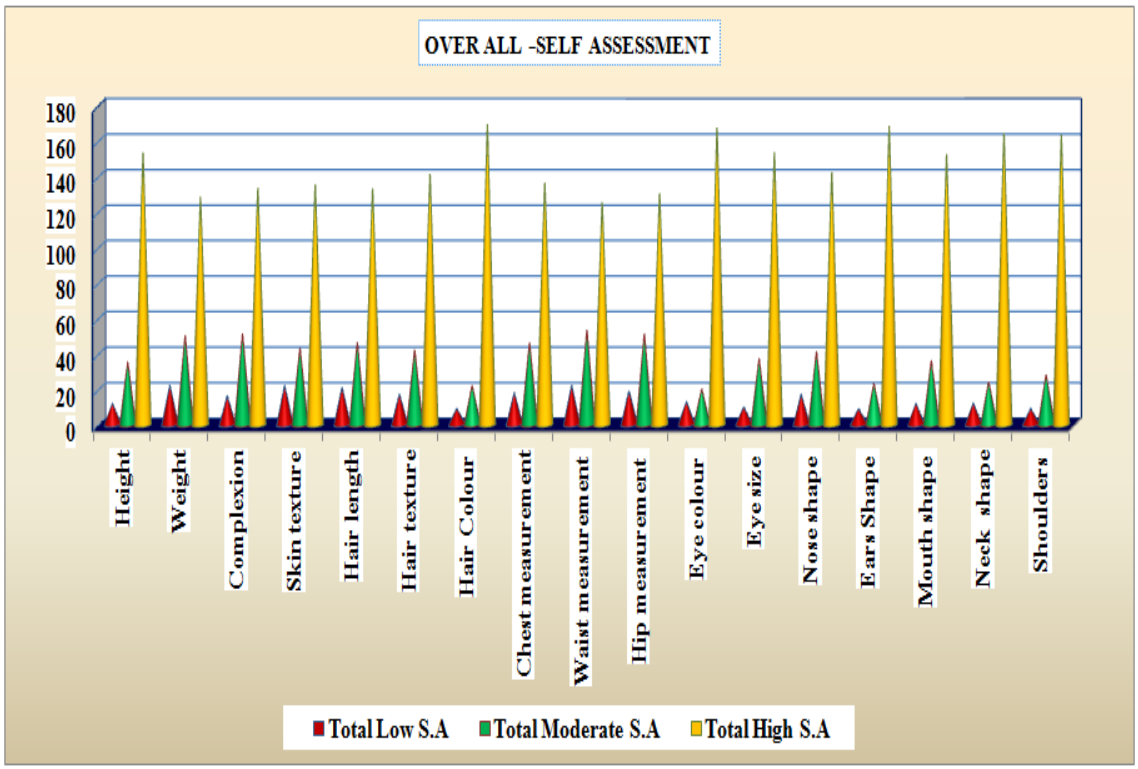

Fig -1. Self Assessment of adolescents

Adolescents are satisfied with many of the dimensions which are less observable, like eye colour, neck shape, ears shape, eye size, and nose shape; generally these dimensions go unnoticed by self and even by the members surrounding them. Though the aspects like height, skin texture and chest measurements are falling under satisfaction level for the respondents the other acceptable dimensions in the society like weight, complexion, waist and hip measurements for more than one fourth of the respondents are under the moderate level of satisfaction. This might be because majority of the adolescents are emphasizing beauty as an important aspect in their life.

Table 3.Over all assessment of adolescents

S.No	ITEM	Low	Average	High
1	I like the way I look	12	47	141
2	My family likes the way I look	12	28	160
3	My friends like the way I look	12	50	138

Overall assessment of adolescents is an indicator of adolescent's acceptance by their family members and friends according to their physical appearance. The results from the table 3, revealed that three fourth of the respondents rated themselves high on all the three aspects and one fourth of the respondents rated themselves average on the aspects, like 'I like the way I look'

and 'my friends like the way I look'. Very less number of respondents came under low satisfaction level.

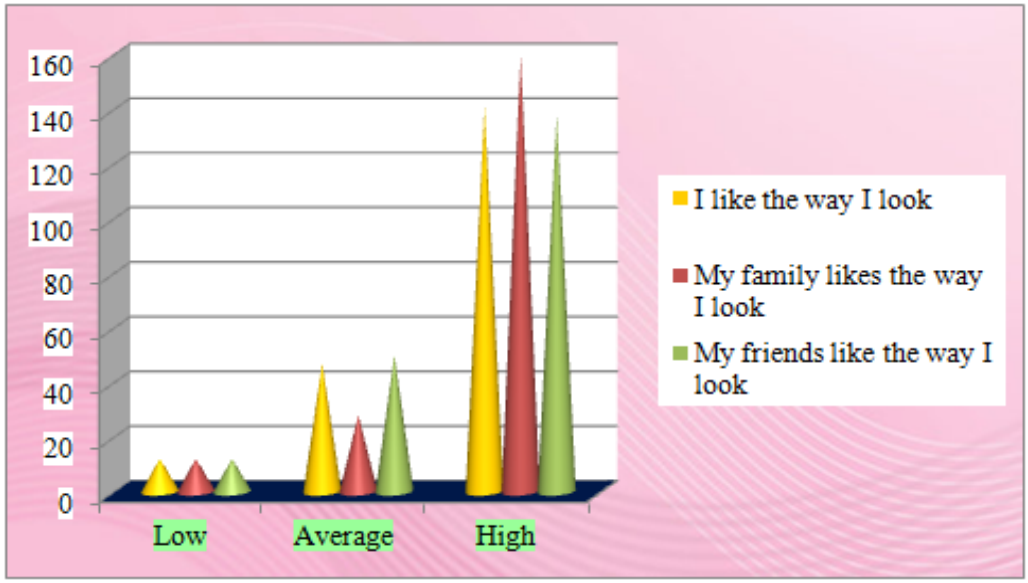

Fig -2. Overall assessment of respondents

This indicates that adolescents are accepted positively despite of their body image concerns by their family and peer group. Though they have concerns regarding their body image they appear to accept themselves in a positive way, without which social adjustments and getting along with others in this society is difficult.

Table 4.Correlation between body image perceptions and self esteem

VARIABLE	GP	SA	RB	IE	OA	SE
General perception(GP)	1					
Self assessment(SA)	.032	1				
Regrets about body(RB)	-.098	.370**	1			
Individual efforts(IE)	.358**	.122	.189**	1		
Overall assessment(OA)	-.129	.440**	.188**	-.062	1	
Self esteem(SE)	**-.114**	**.264****	**.067**	**-.031**	**.194****	**1**

** Correlation is significant at 1%levelof significance.

From the table 4 it is evident that the body image perception variables are positively correlated with self esteem at 1% level of significance. The observations are as follows.

Self esteem is positively correlated with self assessment and overall assessment of body image perceptions. As body image perceptions increased self esteem also increased, this indicates that perceptions about body dimensions like height, weight, complexion, skin tone, hair length, chest measurement, waist measurement and hip measurements under the self assessment domain are positively associated with self esteem.

It was also observed that adolescents with high self esteem have more positive perceptions about their body. Morin *et al.* (2011) in their four year longitudinal study revealed that the relationship between self-esteem and body appearance remained high and stable amongst the adolescent population. Another study conducted by Mellor et al. (2014) found that dissatisfaction with the face, height, and hair was positively correlated with overall body dissatisfaction and self esteem among Malaysian Malays, Australians and Chinese.

Adolescents who were perceived positively in terms of body image concerns by their parents and peer group also had high self esteem. The findings of the present study have some direct or indirect support from the observations made by Holsen *et al.* (2012).

It is interesting to note that general body perception is positively correlated with individual efforts indicating that adolescents who gave importance to beauty, spent more money on clothes, shoes/sandals, fairness creams and moisturizers of individual efforts in order to look beautiful. The same can be seen in terms of individual efforts which are positively correlated with general perception and regrets about body indicating that adolescents who have concerns and ideas about their body dimensions also have regrets regarding body about weight, height and complexion along with other dimensions which are vital in positive body image formation which indicates that adolescents are becoming more conscious about their body and are really worrying about the perfection.

CONCLUSION

Findings of this research show an effective relationship between body image perceptions and self esteem of adolescents, and clearly at the impressionable ages of late adolescence. Result also shows that self esteem of adolescent's increases with inclined and positive perceptions about their physical appearance. It is now clear with the results that, though self esteem is an outcome of many factors, body perceptions are clearly important aspects of self esteem.

The current findings may be informative for further research efforts seeking to understand the relationship between self-esteem and body image perceptions of adolescents. By extending previous research, this study should encourage a continued effort toward coupling the different

dimensions of body image perceptions and understanding its relation with self-esteem when studying adolescents and other sections of the society.

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Self-Forgiveness and Life Satisfaction in People Living with HIV/AIDS

Mudgal, S.[1]*, Tiwari, G. K.[2]

ABSTRACT

The basic goals of the present study were to explore the nature and patterns of relationship between self-forgiveness and life satisfaction of the participants diagnosed with HIV/AIDS and normal healthy persons with no reported chronic physical and/or mental health problems. A total of eighty participants comprising forty diagnosed HIV/AIDS adult patients aged 30 to 42 years (M = 35.50, SD = 4.77) and forty normal individuals aged 19 to 40 years (M =26.81, SD = 4.79) took part in the study whose self-forgiveness and life satisfaction were measured through standardized psychometric tools. The results of the present study demonstrated that the participants inflicted with HIV/AIDS had lower mean self-forgiveness score as compared to their normal counterparts. The same trend was found to be recurring again for the life satisfaction scores of HIV/AIDS and normal participants. The results of the study have been discussed in the light of current theoretical background of forgiveness, life satisfaction and chronic disease. The findings of the study have important implications for policy makers, health professionals, caregivers, students, researchers and administrators.

Keywords: *Self-forgiveness, Forgiveness, Life satisfaction, HIV/AID, Chronic illness.*

Forgiveness has become a popular topic of increasing interest to the researchers in the recent past. The researchers have laid emphasis on the multidimensional nature of forgiveness and the importance of both interpersonal as well as self-forgiveness (Enright & The Human Development Study Group, 1996), the self-forgiveness has still attracted comparatively little empirical attention. Most research programmes have tended to discuss the nature of self-forgiveness only within the context of interpersonal forgiveness theory (Tangney, Boone, & Dearing, 2005), making efforts to draw parallels between forgiveness of self and forgiveness of others. The researches have demonstrated that self-forgiveness is only weakly correlated, and in some studies unrelated to forgiveness of others (Mauger, Perry, Freeman, Grove, McBride, & McKinney, 1992; Thompson, Snyder, Hoffman, Michael, Rasmussen, Billings, Heinze, Neufeld,

[1] Research Scholar, Department of Psychology, School of Humanities & Social Sciences, Doctor Harisingh Gour Vishwavidyalaya, Sagar
[2] Assistant Professor, Department of Psychology, School of Humanities & Social Sciences, Doctor Harisingh Gour Vishwavidyalaya, Sagar
*Responding Author

Shorey, Roberts, & Roberts, 2005), suggesting a need for more focused study on the nature of self-forgiveness.

With the beginning, self-forgiveness has been conceptualized as a process in which offenders choose to acknowledge one's own responsibility for wrongdoing while also retaining one's personal worth given one's inherent ability to learn from past mistakes (Berecz, 1998; Enright et al., 1996). These definitions are heuristic in nature as they depict the process of self-forgiveness unfolding over time and lack the empirical foundation necessary to inspire researchers. Contrarily, Hall and Fincham (2005) defined self-forgiveness as a motivational shift in which one's desires to avoid offense-related stimuli and to retaliate against oneself decrease while one's desire to act benevolently toward oneself increases. They described self-forgiveness as a process maintaining that perpetrators may vacillate between self-condemning and self-forgiving motivations. They further suggested that emotional correlates (guilt, shame, and empathy), social-cognitive correlates (attributions of blame regarding an offense and perceived forgiveness), behavioral correlates (conciliatory behavior), and offense-related correlates (perceived transgression severity) influence the likelihood that a person will self-forgive.

The present research aims to explore the nature and relationship of self-forgiveness and life satisfaction of the participants suffering from human immunodeficiency virus (HIV) which causes the acquisition of immune deficiency syndrome (AIDS) occurring in Indian socio-cultural context. The HIV/AIDS epidemic constitutes an unprecedented biopsychosocial phenomenon impacting not only health but also all aspects of life for the persons living with HIV/AIDS, including marriage and intimate relations, childbearing and parenthood, work and social functioning, as well as psychological and spiritual well-being (Temoshok, 1990, 1998). As health status situation, HIV/AIDS provides perhaps the quintessential paradigm for studying the impact of self-forgiveness on life satisfaction. It may be argued that perceptions of HIV/AIDS are much like perceptions of cancer long ago: a usually fatal, essentially incurable disease associated with stigma and a sense of hopelessness. Unlike cancer, however, HIV is an infectious disease, transmissible by two of the most intrinsic human forces-sexuality and procreation. The intense fear and stigma surrounding transmission in these most intimate of human connections have put the multidimensional concept of self-forgiveness in a central role for those living with HIV/AIDS. How do HIV-infected men and women come to terms with the natural desires to give life and to see life continued through their children, and the realistic fear that their children may be born infected with HIV, or if spared that fate, may become orphans at young age (Goldschmidt, Temoshok, & Brown, 1993)? This is the basic question the present study will try to answer. The present research attempted to develop an understanding of the role played by HIV/AIDS disease in accruing the nature and extent of relationships between self-forgiveness and life satisfaction of the participants.

Hypotheses

On the basis of review of literature, the following hypotheses have been formulated to be tested through the findings of the present study:

1. The mean self-forgiveness score of the non-clinical participants will show significant difference with the mean score on the same measure of the clinical participants.
2. The mean life satisfaction score of the non-clinical participants will be higher as compared to the clinical counterparts.

METHODS AND PROCEDURE

Sample

Forty diagnosed HIV/AIDS patients registered in Antiretroviral Therapy (ART) Center Bundelkhand Medical College, Sagar, M. P. comprising twenty seven males (M = 35.63, SD = 4.58) and thirteen females (M = 33.69, SD = 3.57) and forty postgraduate students from Doctor Harisingh Gour University Sagar, Madhya Pradesh, India comprising twenty eight male (M = 28.00, SD = 4.78) and twelve females (M = 24.17, SD = 5.99) served as the participants in the study. The age range of the participants was from 19-42 years. They belonged to different socioeconomic backgrounds mostly associated with lower middle class Hindu family.

Tools

Two psychometric tools were used in the study with which the self-forgiveness and life satisfaction of the participants have been measured. The short descriptions of the tools are as follows:

a. Heartland Forgiveness Scale (HFS)

The participant's self-forgiving attitude was assessed using translated version of The Heartland Forgiveness Scale (Thompson et al., 2005). The scale was first translated into Hindi and retranslated into English before being administered for actual data collection. The Heartland Forgiveness Scale consists of 18 items, with three subscales consisting six-items each assessing forgiveness of self, others, and situations. Only the subset of six items meant for self-forgiveness was used in this study. Each item comprised seven-point Likert scale (1 = Almost always false of me; 7 = Almost always true of me). The participants were instructed to think about how they have responded to themselves when they have done something wrong. The wording of the items were generally in the direction of higher scores meaning more self-forgiveness, (e.g. With time I am understanding of myself for mistakes I've made and Learning from bad things I've done helps me get over them), and three of these items were reverse-scored so that a higher total score would indicate greater self-forgiveness. The Cronbach's alpha was reported to be .805.

b. The Life satisfaction scale

The level of life satisfaction of the participants was assessed by using life satisfaction scale (Alam & Srivastava, 2001). The scale comprises of 60 items with the alternatives of Yes and No involving the six areas of life viz. Health, Personal, Economic, Marital, Social and occupational. Yes response indicated satisfaction, whereas No signified dissatisfaction with life. Every ‘Yes’

response was assigned 1 whereas 'No' was scored as 0. The sum of the scores was obtained for the entire scale. The test-retest reliability of the scale was found to be .84.

Procedure

As per the requirement of the study, data were collected from two different sources. The data of 40 people living with HIV/AIDS were collected from Bundelkhand Medical College, Sagar, M. P. with the permission of the Nodal officer of ART center whereas normal participants from Doctor Harisingh Gour Vishwavidyalaya, Sagar, M. P. with no physical/mental health problems were the other source of data. The instructions were made clear orally to them first before they were supplied with the questionnaires and requested to answer each item carefully as per the directions written in the beginning of each scale. The participants were informed that participation was voluntary and responses will be kept confidential. Their written consents were collected before they actually started to answer the items of the questionnaires of the study. The average length of time needed to complete the questionnaires was approximately 20 minutes.

RESULTS

The results revealed that the clinical participants exhibited lower mean score (Mean = 24.35, SD = 4.96) on self-forgiveness measure as compared to the non-clinical participants (Mean=29.18, SD = 2.60). In the same manner, the clinical group showed similar performance in evoking lower mean score (Mean = 38.50, SD = 2.60) on life satisfaction measure as compared to the normal healthy (Mean = 44.25, SD = 3.33).

Table 1: Mean self-forgiveness and life satisfaction scores of clinical and non-clinical participants

S. No.	Participants	Measures	Mean	SD	N
1.	HIV/AIDS	Self-forgiveness	24.35	4.96	40
		Life satisfaction	38.50	4.80	40
2.	Normal	Self-forgiveness	29.18	2.60	40
		Life satisfaction	44.25	3.33	40

The mean scores on self-forgiveness ($t= 5.23$, $df = 39$, $p > .001$) and life satisfaction ($t= 6.19$, $df = 39$, $p > .001$) of the clinical and non-clinical participants showed statistically significant difference.

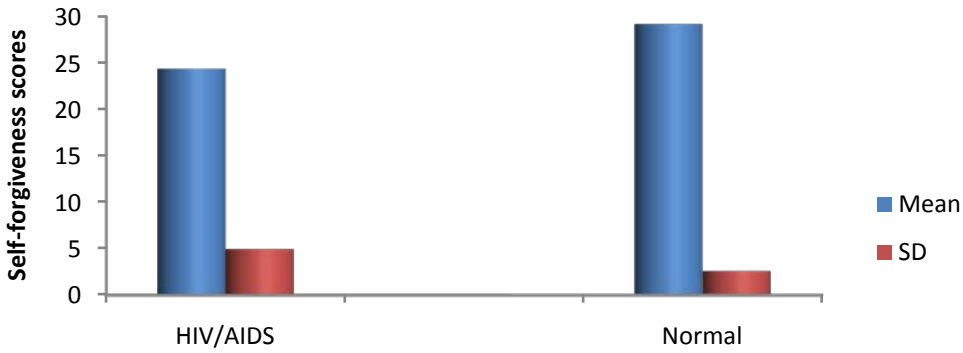

Figure 1: Mean self-forgiveness scores of HIV/AIDS patients and normal participants

Thus, there was a significant difference on the level of self-forgiveness among HIV/AIDS patients and their normal counterparts. Analysis of life satisfaction score also showed the same trend. These results have been presented in table 1 and Figures 1 and 2.

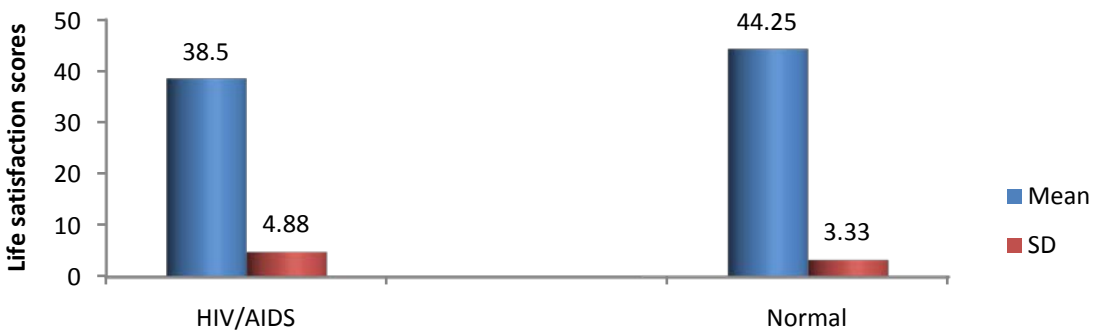

Figure 2: Mean life satisfaction scores of HIV/AIDS patients and normal participants

DISCUSSION

The results of the study made it evident that nature of self-forgiveness and life satisfaction of people living with HIV/AIDS and the normal participants were shaped by the fact that whether they were inflicted by the chronic disease of HIV/AIDS or not. The chronic illness like HIV/AIDS has a major impact on various aspects of the patient's life. The results of the study showed that HIV/AIDS patients emitted lower level of mean self-forgiveness score as compared to normal people resulting into the confirmation of first hypothesis of the study. Second hypothesis also got approved as HIV/AIDS patients evoked lower mean score on life satisfaction measure as compared to the normal participants. The values of t-test evinced that the mean scores on these two measures achieved by the two groups of participants were statistically significant.

The HIV/AIDS patients have many reasons of being affected with this kind of chronic illness but irrespective of reason being HIV positive is really a taboo in Indian society. There are plenty of societal and emotional harassments have to be faced by the HIV/AIDS patients and in this condition it is very difficult to forgive another person who is responsible for such condition as well themselves for having followed along with their decisions consequent of which it turned into a fatal disease like HIV/AIDS. While determining the reasons behind self unforgiving state, self blaming, guilt and shame play an important role. When a person feels guilt and starts blaming himself/herself, it becomes very difficult for him/her to forgive the self because once feeling of self blame occur our ego-defense mechanisms almost stop working.

The mean life satisfaction score of HIV/AIDS patients were found to be lower because the long duration of chronic disease might have made the patients prone to suffer stress (Godsoe, 2008). In general, chronic diseases have multiple impacts on the psychological functioning of the patients. Chronic disease of HIV/AIDS has been reported to affect perceptions of body image and has resulted into reduced body image satisfaction/life satisfaction (Jain & Tiwari, in press) and self-esteem (Tiwari, 2014; Tiwari & Kumar, 2015) of the participants. Moreover, the HIV/AIDS has also been found to affect emotion regulation processes and caused inappropriate application of emotion regulation strategies viz., emotional suppression and cognitive reappraisal on the part of the participants (Tiwari, 2015). The people with chronic diseases may become more sensitive, making it more easily offended than those with normal health (Godsoe, 2008). The Chronic disease patients may also have problems in their interpersonal relationships and self-concept (Tiwari, 2014). Morrison and Bennett (2009) reported that the inability of patients with chronic diseases in expressing their complaint to the others can make them feel upset and non-understandable. This condition can certainly cause discomfort and result into interpersonal conflicts. The pain they feel can also hamper and disturb their daily functioning. For example, patients with lower back pain typically will experience a decline in cognitive performance (Weiner, Rudy, Morrow, Slaboda, & Lieber, 2006). This condition can affect the patient's ability to manage information for daily functioning. Psychologically, this can also lead the patients to feel depressed, anxious, and hopeless to face their chronic diseases. In general, the individuals with chronic diseases like HIV/AIDS experience a decline on satisfaction with their life (Jain & Tiwari, in press; Nowakowski, 2014). Usually, such person will also will experience a change in their daily activities as a results of physical impairment caused by chronic disease. However, the people with chronic disease often face a more complex situation than the normal people. They tend to undergo more and more medical treatment and spend more money for it (Zulman, Asch, Martins, Kerr, Hoffman, Goldstein, 2013). In addition, multiple chronic diseases deteriorate the physical condition of the elderly so their daily activities also become more limited (Schilling, Wahl, & Oswald, 2013) and affects the patient's ability to work (Zulman et al. 2013). Physical impairment experienced due to this condition also lowers patient's psychological functioning (Schilling & Wahl, 2006).

CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

It can be concluded from the findings of the study that people living with HIV/AIDS have lowered level of self-forgiveness and life satisfaction as compared to the normal healthy participants. The HIV/AIDS patients showed lower mean scores on self-forgiveness as well on life satisfaction as compared to their normal counterparts. It is expected that self-forgiveness based psychotherapeutic intervention techniques would do well in the case of people suffering from HIV/AIDS. A very small sample, limited geographical area and selection of only two variables constitute some of the limitations of this study. The future researches may be conducted comprising relatively a large sample with varying socio-cultural attributes and with multiple variables. Another suggestion for future research is that they should involve qualitative methods as the questionnaires did not provide them with a sufficient opportunity to express themselves. The results and conclusions of the study have important implications for future researchers, planners, policy makers and health professionals who are associated with the services of people inflicted with chronic disease like HIV/AIDS.

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Intentional Enrichment of Subjective Well-Being

Dr. Mrunal A. Bhardwaj[1]*, Shraddha A. Raravikar[2]

ABSTRACT

The key objective of a present article is to propose and explain "Intentional Enrichment technique" that provides activities to enhance the level of Subjective Well-being and to examine the study that is carried out to test the effectiveness of the technique. "Intentional Enrichment technique" assists individual to take up his responsibility of own happiness and actively try for it. The technique takes support of Fordyce 14 Happiness Fundamentals (1977, 1983) and Keyes's model of mental health (Keyes and Lopez, 2002). According to the technique, efforts for Intentional Enrichment can be divided into five ingredients i. e. Enrichment of the Self, Enrichment of Thoughts, Enrichment of Relationships, Enrichment of the Work, Enrichment of society. The field experiment is carried on one hundred and forty junior and senior college teachers. The technique proved efficient in improving the level of subjective well-being.

Keywords: *Intentional Enrichment Technique, Subjective Well-being*

A commonly shared goal of life for every individual is to be happy. It comprises seeking pleasure and avoiding negativities. But negativities are the part and parcel of life. In fact our pleasure would lose its very existence in absence of pain. Still excessive long-lasting physical or mental pain leads to negative physiological and psychological consequences. So we try to tip the balance of positive. Life bestows us with both joyous and saddening events, gratifying as well as disheartening relationships and more or less of material possessions. These situational factors along with internal qualities and subjective evaluations define our level of happiness. Despite physically and mentally taxing stressors and resulting pain and unhappiness we don't give up on a search for happiness. With the help of the adaptation process we overcome pain and try to remain happy. Apart from overcoming pain, we also strive for the pleasure. Some manage to remain stable and happy in chronic physical ailments and extremely poor environmental conditions. Some cannot be happy even in normal or affluent circumstances. Most people fall on the middle of the continuum. No matter wherever one stands the search goes on. But still in absence of major crisis, we see "not so happy" people around and many times we also remain so.

Our feelings change in reaction to the surrounding events. Simultaneously we judge the consequences in a momentary, domain specific as well as broader context of our life. Thus

[1] HOD and Vice-Principal, L. V. H. College, Nashik, MH
[2] Asst. Professor, M. V. P.'s ASC College, Ozar (Mig), MH
*Responding Author

subjective well-being involves various components: positive affect (many pleasant experiences) and low levels of negative affect (lesser unpleasant experiences), satisfaction pertaining to particular domains and satisfaction with life as a whole. If analyzed carefully, it becomes clear that the components are our passive reaction to the events. We have a very little, if any control over them. If we try to maximize positive affect with indulging ourselves, those effort gives momentary pleasure. Even ecstatic experiences make us happy for a short duration. With the process of adaptation very shortly we return to the baseline. In the context of positive affect the process is somewhat undesirable but it helps us to sustain pain and survive in extremities. To some extent negativities can be avoided but many times they keep falling and we become passive recipients left helpless. The satisfaction in important domains of life like relationships, work, and finances are also partially dependent upon significant interpersonal and environmental interactions. And satisfaction with life as a whole is a sum of these components. Given the lack of total control over all these factors, it's better to be self-reliant in our pursuit of happiness. Of course total self-reliance is unrealistic, impossible and somewhat abnormal goal; at least we should be aware of our ability to enhance our sense of well-being. An effort should be done to change overall evaluation of life by changing our perspective, strengthen ourselves emotionally and achieve highest possible emotional resistance. In short to do every possible thing to remain emotionally fit. Just as we keep our body fit with food nutrients and exercise, we should actively nurture our mind. At the outset, we must actively assume our responsibility to keep oneself happy and perseveringly keep trying. The ultimate goal shall be to make life worthwhile through self-efforts i.e. Intentional Enrichment. A rationale behind effort is the incompatibility of positive and negative emotions. The potential effects of negative experiences can be offset by positive emotions such as joy and contentment. Fredrickson, Mancuso, Branigan, & Tugade (2000) have found evidences of "undoing" potential of positive emotions. Fredrickson and Losada (2005) also found that a mean ratio of 2:9 positive to negative emotions predicts human flourishing. Thus environmental, situational and interpersonal negativities can be offset by self gifted positive experiences and cumulative effects of such persistent efforts would invigorate mental health and enhance well-being.

The key objective of this present article is to propose and explain "Intentional Enrichment technique" that provides such activities and to examine the study that is carried out to test the effectiveness of the technique.

Intentional Enrichment Technique

According to Lyubomirsky and colleagues, 50 % of a person's happiness is determined by genetic factors and another 10 % is determined by circumstances. This still leaves 40% for the effects of intentional activity. Intentional activities mean those activities that are consciously chosen and require sustained efforts. "Intentional Enrichment technique" assists individual to take up his or her responsibility of own happiness and actively try for it. The technique takes support of Fordyce 14 Happiness Fundamentals (1977, 1983) and Keyes's model of mental health (Keyes and Lopez, 2002). It is an effort to provide simple tools to gain the much prized

outcome i. e. to be happy from within and without superficial support of worldly materials and without relying unduly heavily on others for our happiness. The tactics are designed on the basis of 'Intentional Enrichment Technique'.

The efforts for Intentional Enrichment can be divided into five ingredients-

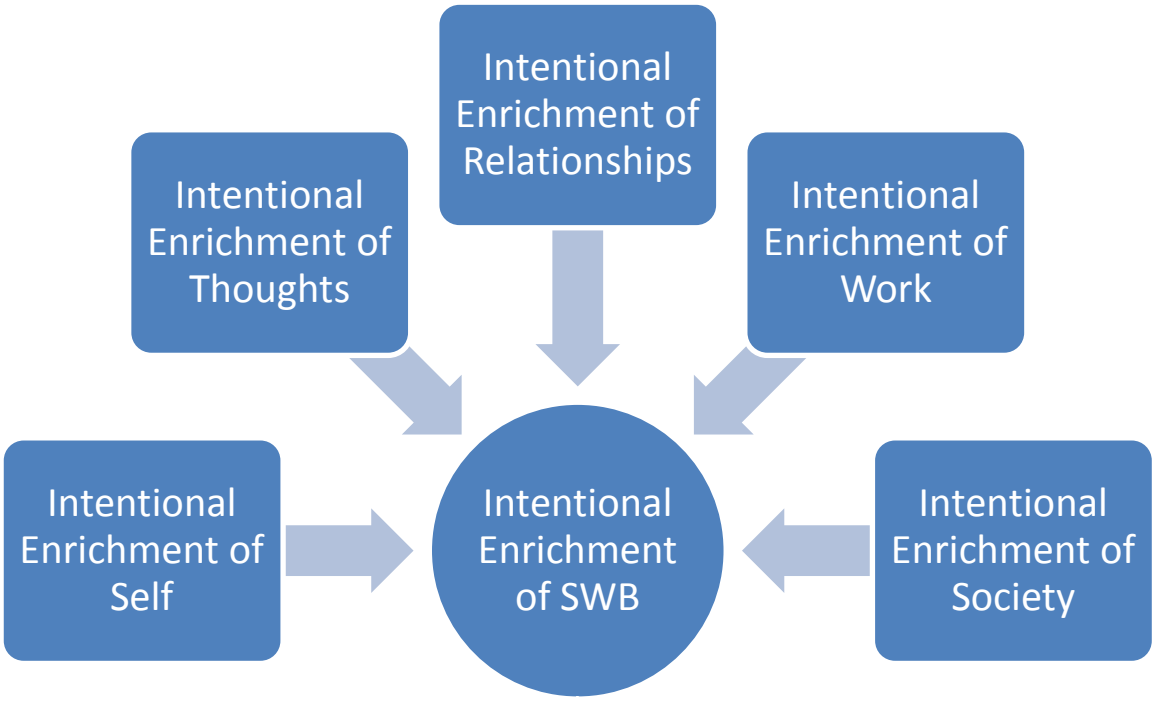
1. Enrichment of the Self
2. Enrichment of Thoughts
3. Enrichment of Relationships
4. Enrichment of the Work
5. Enrichment of society

Initial requisites of Enrichment

1. Individual should be ready to take up his or her responsibility of own happiness
2. Individual should take active efforts to boost his or her happiness
3. The intention should not be the avoidance of pain but to offset its effects through self-efforts

The diagrammed representation of the model is presented below:

- **Intentional Enrichment of Relationships**



The model is based on Fordyce's 14 Happiness Fundamentals (1977, 1983) and Keyes' concept of Mental Health (Keyes and Lopez, 2002).

Significance and Implementation

Enrichment of the Self

The whole focus of the effort here is self. First attempt should be to improvise on oneself. It involves purging off mind, keeping it positive, developing and nurturing good habits and realizing ones potential. The aim is to raise positive affect, self knowledge, self esteem, optimism.

Activities

1. Smiling
2. Possession List (count your blessings)
3. Giving small gifts (possibly self-made)
4. Smiling at strangers
5. Poison Pen
6. Humorous literature
7. SWOT
8. Accept and cheer the self
9. Goal-setting
10. Schedule for pursuing greatest passions

Enrichment of Thoughts

Albert Ellis has truly said that we feel the way we think. Though all events are not controllable, our evaluation of them defines our emotions. So with our thoughts we can make the dark things lighter. It also helps to maintain positive emotions and being resilient. The goal is to increase positive affect and optimism.

Activities

1. Demonstration of “We feel the way we think”
2. Understanding Albert Ellis’s ABC
3. Story critique
4. Re-evaluation of 5 negative life events
5. Reminiscing
6. Deliberate positive monologue
7. Auto suggestions
8. Think about what we don’t have! (look downward)
9. Wall paper
10. Find pleasure in taken for granted things

Enrichment of Relationships

We have a strong desire to belong and to love. Close relationships give meaning to our existence so much so that they affect our identity, self esteem, sense of worth in particular and sense of well-being and health in general. Of many factors that contribute to well-being, only relationships consistently predict happiness across widely different cultures. So greater the

efforts, greater will be the uplift. The effort is to strengthen the close ties, broaden social network, ensuing satisfaction, boost gratitude and helping.

Activities

1. Gratefulness chits
2. Appreciation
3. Create a love account
4. Saying please and sorry
5. Forgiveness chits
6. Walk in others' shoe
7. Focus on others' virtue
8. Note and capitalize on special events
9. Writing to forgotten friends
10. Unconditional help

Enrichment of the Work

We spend two third of our time at work. More than half of our waking time is consumed by our work and related commuting. Also it decides our access to material resources, societal status and self image. Its enrichment will truly lead to rich life. The aim is to raise self esteem, gratitude and positive experiences.

Activities

1. Using a decision tree
2. Search for a bigger meaning in work
3. Make a list of what work gives you
4. Dedicate and do your best
5. Congratulating oneself
6. Decorate the work setting
7. Optimum use of commuting time
8. Savor the path (Seek enjoyment rather than accomplishment)
9. Develop Intrinsic motivation
10. Mentoring

Enrichment of society

Till now, all the focus was on personal gratification. After certain limit the focus can prove selfish and stagnated. We own a great credit to people and environment around. So paying back is very satisfying to self and others. The efforts can lead to happiness of society in general. The noble intent is to raise self esteem, hope, helping, gratitude and happiness.

Activities

1. Search for a bigger meaning in life
2. Spread a smile
3. Tell a tale
4. Plant a tree

5. Send plastic for reuse
6. Become a volunteer
7. Work on a cause
8. Lend an ear
9. Lend a book
10. Share your enrichment

METHOD

Participants

The one hundred and forty[140] junior and senior college teachers of Nasik, Maharashtra were selected as subjects according to the availability and willingness to participate in an experiment and assigned to two groups i. e. one control group and one experimental group,70 teachers in each group.

Material and Procedure

This field experiment was carried out in following steps:

1. The total 140 were selected as subjects according to the availability and willingness to participate in an experiment and assigned to two groups. i. e. one control group and one experimental group.
2. Pre- test: The verbal reports and scores on measures of subjective well-being were obtained (to get the initial base-line). The Satisfaction with Life Scale by Diener, Emmons, Larsen, and Griffin, (1985) was used for the purpose.
3. Manipulation of IV: Implementation of Intentional Enrichment Technique. The total 50 activities were given to the subjects.
4. Post-test: Again the verbal reports and scores on measures of subjective well-being were obtained (to know the difference between initial level of happiness and post to the implementation of Intentional Enrichment Technique). The Satisfaction with Life Scale by Diener, Emmons, Larsen, and Griffin, (1985) was used for the purpose.

RESULTS

Preliminary Analysis

We first examined Pre-Test level of Subjective Well-being expecting to find no difference. Not much difference in the initial level of Subjective Well-being was found in the control group (M=25.03) and treatment group (M=25.23).

Hypothesis Test

To test the hypothesis that the level of subjective well being would be greater in college teachers from Experimental group following Intentional Enrichment Technique than college teachers from Control group, we conducted *t* test. As expected we found a significant difference between the means of pre-test (M =25.23) and post-tests of treatment group (M=27.86). The value

standard sigma scores (z= 1.68) exceeds the critical value of 1.65 (one-tailed test) at 5% level. But no significant difference was found between the means of pre-test (M=25.03) and post-test (M=25.31) of the control group. The value of standard sigma course (z=0.22) does not exceed the critical value of 1.65 (one-tailed test) at 5% level.

The table 1 contains the mean scores of treatment group as measured before the implementation of Intentional Enrichment Technique and the mean scores of treatment group after the implementation of Intentional Enrichment Technique. The table 2 contains the mean scores of control group at the beginning of experiment and mean scores of control group after the fifty days of the initial measure.

Table1. Mean and SD for pre-test and post-test of treatment group

	Mean	SD
Pre-test	25.23	6.79
Post-test	27.86	8.12

Table2. Mean and SD for pre-test and post-test of control group

	Mean	SD
Pre-test	25.03	7.85
Post-test	25.31	7.19

DISCUSSION

In the present study we tested the effectiveness of Intentional Enrichment Technique in enhancing subjective well-being. The statistical analysis showed that the technique proved efficient in improving the level of subjective well-being and served the purpose. However the care should be taken while generalizing the findings as an experiment is carried out on a sample of junior and senior college teachers that belongs to particular class of society.

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Web Resources

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Mental Health among Government School Teachers

Chanderkant Gorsy[1]*, Neeraj Panwar[1], Sandeep Kumar[1]

ABSTRACT

Teaching is being considered as one of the noblest profession since ancient times. With the changing socio-economic scenario and increasing unemployment, the values of teachers' and their professional concern with the job have forcibly undergone a drastic change which adversely affects their mental health. The level of mental health of a teacher has been found affected with numerous personal as well as professional demands. Health of teachers, on social, physical and mental health domains adds to the efficiency not only to their professional growth and development but also to their personality. Moreover, they have also been considered as the constructors of the future of a country. Keeping these facts into the consideration, present study aimed to access the level of personal mental health of school teachers, particularly those who work in the public sector schools. Survey method has been employed and Mental Health Index (MHI) was used for collecting the data. 100 secondary and higher secondary school teachers were included in the study. The data was analyzed using descriptive analysis and to find the differences for gender and locations t- test was applied. The t-values reveals that significant gender differences exist among government school teachers and male school teachers were found better on mental health than their female counterparts. Additionally, teachers posted at schools located under urban area were found higher on mental health as compared to teaches posted at schools located under rural areas.

Keywords: *Mental health, Gender, school teachers Urban, Rural*

Schools are not the places where students went to study but they are being considered as the temple of education where teachers play similar role being observed by the priest of any religious place. Performance of the school is the collective team work of teachers as well as students. Teachers not only impart education to the students but also act as a bridge to fill the gap between students, principal, management and parents. Their cordial relation with students reflects in the behavior and speech of teachers. Sound professional relations of a teacher with students, their parents, colleagues, and management may lead to their better mental health.

In the present world of professional competence everyone is threatened by increasing competitions and degraded circumstances. Health is and has been always one of the most important areas where focus is necessary for all times. Resultantly the concept of health has been

[1] Ph.D, Research scholar, Department of Psychology, Maharshi Dayanand University, Rohtak (Haryana)
*Responding Author

extended beyond the proper functioning of the body; it includes controlled emotions, a sound and efficient mind. In simple words it means that mind and body both are working efficiently and harmoniously (Kaur, 2007).

It is evident from the previous researches that mental health plays a pivot and vital role in human life. It is not only important but essential for survival as a social being. No area of human life is beyond the range of mental health. It includes every aspect and dimension of human personality and the individual's adjustment to own self, others and environment. The main characteristic of mental health is adjustment, magnitude of which decides the status of mental health. The greater the degree of adjustment, the greater will be the mental health and lesser degree will lead to the lesser mental health. The mentally healthy individual can adapt him or herself to every best and worst condition of life and environment. The expression '*Mental Health* 'consists of two words-

The word 'mental' usually implies something more than purely cerebral functioning of a person. It includes one's emotional affective states. It is the equilibrium in one's Sociocultural context that is reflected by the relationship one establishes with others.

Similarly, 'health' refers to more than physical wellbeing. It also connotes the individual's intra-physic balance, the interaction of one's physic-structure with the external and social environment (Kaur, 2007). For example, a person who is academically sound and also knows what is to be taught but at times is not able to impart it due to certain factors of adjustment with his/her environment.

Mental health stands for the health of the mind, "*The wholesomeness of mind***"**− analogous to the wholesomeness of the body as implicit in physical health. Accordingly, mental health is concerned with the health of one's mind and its functioning in the same way as the physical health is concerned with the health of one's physical organs and their functioning**.**

Mental health, in layman terms, is a level of psychological well-being, or an absence of a mental disorder (Singh, 2004). From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. According to World Health Organization (WHO) mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others.

Kornhauser (1965) connotes that mental health includes those behaviors, perceptions and feelings that determine a person's overall level of personal effectiveness, success, happiness and excellence of functioning as a person. It depends on the development and retention of goals that is neither too high nor too low to permit realistic successful maintenance of belief in one's self as a worthy, effective human being. Further, it is the condition in which the individual manifest

through self-evaluation, adjustability, maturity, regular life, absence of extremism satisfactory social adjustment and satisfaction from his chief occupation. Complete mental health is an ideal. Any individual who possesses the greatest number of these qualities will be nearest the ideal (Singh, Chandra & Parihar, 2011).

Singh and Gupta (1983) described six indices of mental health i.e. emotional stability (experiencing subjective stable feeling which have positive or negative); over-all adjustment (achieving an overall harmonious balance between demands of various aspects of environment, such as home, health, social, emotional and school of the one hand and cognition on the other);autonomy(a stage of independence and self-determination in thinking);security-insecurity (a high or low sense of safety, confidence, and freedom from fear, apprehension or anxiety particularly with respect to fulfilling the person's present or future needs); self-concept (sum total of the person's attitude and knowledge towards himself and evaluation of his achievements); and intelligence (general mental ability which helps the person in thinking rationally, and in behaving purposefully in his environment).

While, the interpretation of mental health by Das (2008) is "Good mental health can be achieved by following the principle of mental hygiene, which is the science of the investigation and application of those measures that prevent mental disorder. Mental health is a way of living satisfactorily and effectively with other members of the society**"**.

There have been many studies conducted to access the level of mental health among school teachers in relation to various psychological variables. It is important to emphasize that these different determinants interact with each other in a dynamic way, and that they can work for or against a particular individual's mental health state. Table 1 provides an illustrative set of factors that may threaten or protect mental health. For example, an individual's level of self-worth could be enhanced or diminished depending on social support or economic security at the household level, which in turn might be influenced by the extent of political stability, social justice or economic growth in a country.

Table 1: Mental health determinants
(c.f. Risks to mental health, WHO, 2012)

Level	**Adverse factors**		**Protective factors**
Individual attributes	Low self-esteem	⟷	Self-esteem, confidence
	Cognitive/emotional immaturity	⟷	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	⟷	Communication skills
	Medical illness, substance use	⟷	Physical health, fitness

Social circumstances	Loneliness, bereavement	⟷	Social support of family & friends
	Neglect, family conflict	⟷	Good parenting / family interaction
	Exposure to violence/abuse	⟷	Physical security and safety
	Low income and poverty	⟷	Economic security
	Difficulties or failure at school	⟷	Scholastic achievement
	Work stress, unemployment	⟷	Satisfaction and success at work
Environmental factors	Poor access to basic services	⟷	Equality of access to basic services
	Injustice and discrimination	⟷	Social justice, tolerance, integration
	Social and gender inequalities	⟷	Social and gender equality
	Exposure to war or disaster	⟷	Physical security and safety

Ananda (1989) conducted a study on mental health of schoolteachers using a mental health scale and observed that 59 % of teachers were mentally healthy. The state of working bears no relation to mental health while social values were positively related to mental health of teachers.

Kumar (1992) observed that if a teacher is with bad mental health it not only tends to incapacitate himself for the performance of his multifarious duties in the school but also creates difficulties and problem for his students.

Kaur (2007) investigates occupational stress, mental health and coping resources of high and higher secondary school teachers and their relationship. The results revealed that sometimes teachers feel stressed due to role overload, responsibilities and physical stressors present in school. Whereas, teachers those who are mentally healthy use coping resources to combat the effect of occupational stress. They use recreational activities such as watching T.V., listening music, getting social support from friends to relief from mental tensions, etc. The result also indicated that correlation between occupational stress and mental health is negative. Occupational stress and coping resources also tends to be negative. Correlation between mental health and coping resources is positive and significant.

Srivastava and Khan (2008) conducted a study to know the impact of mental health on the level of burnout of the teachers teaching at different education level. They concluded that teachers with low mental health are more prone to burnouts than the teachers of average and high mental health.

Srivastava(2010) assessed the personality and mental health among primary and secondary teachers. The result indicates that personality types/traits influence the mental health of primary and secondary teachers and extrovert teachers enjoy better mental health as compared to introvert teachers.

Kale (2011) conducted a study on awareness of mental health among newly admitted B.Ed. Students. The researcher has applied survey method for collecting the data. The results reveal that there is great awareness about the mental health among newly admitted B.Ed students.

Kumar (2013) reported results of t-test reveals that urban elementary school teachers scored higher mean scores on mental health ($t = -16.06$; $p<.01$) whereas, elementary school teachers from rural schools are scored low on mental health. Meaning thereby, awareness of self-mental health would make elementary school teachers' to cope with stressful situation in an enhanced way and are in a better position to perform appraisal of pupils' undesirable behaviour at elementary school level.

In sum a teacher can often create a classroom environment in an image of their own childhood experiences and cultural influences (Kroeger & Bauer, 2004). This image could mimic how they were taught at school, and in still their own beliefs on how homes and lives are organized, believing that this is the right way and is how will be (Thorsborne & Vinegrad, 2006). Some of the researchers like Langley (2008) suggested that teachers need to consider there are times when the problem is within themselves and not the child.

OBJECTIVES

On the basis of provided conceptual description and literature review regarding mental health among school teachers following objectives were proposed for the present study:

1. To assess the mental health among government school teachers.
2. To find out gender differences among school teachers with regard to mental health.
3. To compare mental health level of school teachers posted at urban located schools versus school teachers posted at rural located schools.

Hypotheses:

1. There would be significant gender differences with regard to mental health.
2. There would be significant differences between school teachers posted at schools located at rural and urban areas.

METHODOLOGY

Sample

Random sampling technique has been used for selecting the sample. The investigator selected 100 secondary and higher secondary school teachers within the age range of 35 to 50 yearsfrom various districts of Haryana. For the final testing 100 participants were equally divided into two group's male and female (50 in each group).All the teachers hold at least five years of minimum teaching experience at present posting and living with family members.

Tools

The following tools were used for the present investigation:

1. **MENTAL HEALTH INDEX [MHI-38; Davies, Sherbourne, Peterson, & Ware (1998)]:** All of the 38 MHI items, except two, are scored on a six-point scale (range 1-6). Items 9 and 28 are the exception, each scored on a five-point scale (range 1-5). The pre-coded values of each item are shown on the copy of the instrument on the preceding pages.

Procedure

After getting the formal permission from the Principals' of concerned institutions, data was collected. Participants were briefed about the nature and the purpose of the research in order to receive the reliable data. They were assured about the confidentiality of the data. Instructions were given regarding the questionnaires. The scale was filled by the participants, while they were on duty and collected immediately after completion.

Statistical analysis

Descriptive analysis and t test were used for the assessment of teacher's mental health. The data was analyzed with the help of SPSS-21. Obtained statistical results are given in the section following.

RESULTS & DISCUSSION

The results of statistical analysis for the present investigation has been presented with the help of tabulation, show the descriptive statistical values for the said variables. Additionally, gender differences and differences between teachers posted at urban and rural located schools t-test was applied.

Table 1: Shows descriptive statistics for the overall data.

Variable	N	Mean	SD	Skewness	Kurtosis
Mental Health	100	99.92	38.18	.266	-1.051

It is evident from the Table1 that mean values for mental health are falling on the higher side. Which means that majority of government teachers comprises the present sample experience higher mental health associated with their occupational demands.

Table 2: Mental health of male and female school teachers

GENDER	N	Mean	SD	t -value	Level of significance
Male	50	108.86	39.01	2.39	0.02
Female	50	90.98	35.49		

Form the Table 2, indicates the difference of mental health between both the groups (male and female). It is evident that mental health of male and female school teachers has significant difference($t = 2.39$; $p \leq .02$).Male experience better mental health as compared to their female counterparts. Reasons may be, single role as a teacher by male teachers whereas females has to maintain personal as well as professional fronts even if commute long distances, men can manage whereas females has to face lots of difficulties.

Table 3: Mental health of rural and urban school teachers

Locality	N	Mean	SD	t- value	Level of Significance
Rural	50	79.16	33.32	-6.46	0.001
Urban	50	120.68	30.91		

Form the Table 3, it is found that there is significant difference between rural and urban school teachers mental health ($t = -6.46$; $p \leq .001$). Government school teachers posted at urban areas are found high on mental health as compared to those who are posted at rural areas located schools. Reasons may be, better commuting facilities, short distance between school and home, connectivity to district authorities and better life style (facility of parks for walks, medical facilities, better network quality, access to hobby classes for self and children etc.).

In sum, it has been found that the male school teachers' mental health is found to behigher than the female school teachers. Additionally, based on locality the urban school teacher is found to be higher than the female school teachers. Hence, both the hypotheses is accepted.

CONCLUSION

Mental health is a specialized field of psychiatry and its objective is to safeguard mental health by preventive measures, controlling factors effective on the development of mental diseases, timely diagnosis of mental diseases, prevention from complications due to relapse of mental diseases and the providing a healthy environment as a contributory factor on sound human relationship (Milanifar, 1997). Present study investigates this issue and tries to provide answers for the following question with regard to mental health of school teachers.

Ananda (1989) conducted a study on mental health of school teachers using a mental health scale and observed that fifty nine percent of teachers were mentally healthy. The development of our country is in the hands of the teachers. Good mental health is highly essential for all in general and particularly teachers. Poor mental health of teachers has an adverse effect indirectly as well as sometimes directly on the development of learner's personality. All the school administrators and higher authorities should take keen interest in developing and maintaining positive mental health of teachers and students.

Therefore, it is necessary to establish guidance and counseling cell in all the schools. It will help to solve mental, psychological and health related problems of teachers and students. Mental health promotion related workshops, seminars, groups discussions and conferences should be

organized at the interschool level then only teachers and students benefited. The teachers' mental health is directly related to the work of classroom. Thus, good mental health of the teacher should as important qualification as academic competence.

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